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The Effectiveness Of A Transaffirmative Cognitive Behavioral Therapy Group-Based Intervention To Help Transgender Individuals Suffering From Depression

Joy Riach
joyvriach@gmail.com

The University of San Francisco

THE EFFECTIVENESS OF A TRANSAFFIRMATIVE COGNITIVE BEHAVIORAL THERAPY GROUP-BASED INTERVENTION TO HELP TRANSGENDER INDIVIDUALS SUFFERING FROM DEPRESSION

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Joy Ventura Riach, M.S., M.A.
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Joy Ventura Riach
Candidate, Joy Ventura Riach

January 6, 2021
Date

Dissertation Committee Signatures

David A Matthews
Chair

1/13/2021
Date

Committee Member

1/13/2021
Date

Committee Member

01/11/2021
Date

Administrator Signatures

David A Matthews
PsyD Program Director

1/13/2021
Date

Margaret Baker
Dean, School of Nursing and Health Professions

1/14/2021
Date

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Dedication

This dissertation is dedicated to my family.

Acknowledgments

I would like to acknowledge my dissertation committee for their support, patience, and guidance.

THE UNIVERSITY OF SAN FRANCISCO

Dissertation Abstract

The Effectiveness of a Transaffirmative Cognitive Behavioral Therapy Group-Based Intervention to Help Transgender Individuals Suffering From Depression

Transgender individuals report higher levels of elevated symptoms of depression and anxiety due to psychological distress caused by pervasive transphobic discrimination and prejudice that persist in pathologizing and stigmatizing their lived experiences. An important first step would be to develop, implement, and assess transaffirmative interventions that address the mental health issues that this population is particularly susceptible to, such as depression. This current study was designed to assess the effectiveness of one such culturally adapted intervention, which was a 5-week-long, group-based therapy developed for treating depression in transgender individuals using cognitive behavioral therapy (CBT). This was then followed with one final session 1 month after the last session. The researcher hypothesized that participating in this intervention would result in a clinically significant reduction in depressive symptoms among the participants. The data were analyzed using a one-way repeated measure analysis of variance (ANOVA; Field, 2016) and a paired samples *t*-test (Laerd Statistics, 2018). The study consisted of 14 transgender individuals who were divided into three treatment groups. In March 2020 due to the COVID-19 pandemic, the researcher adapted the intervention protocol to conducting individual therapy sessions over the phone. The results indicated that there was a significant difference in the means depressive symptoms scores for T1(preintervention) and T3 (1 month postintervention). Future researchers may

wish to use a larger participant pool that includes a greater diversity of ethnic, cultural, geographical, and age groups. With this more diverse sample, more extensive analysis could be conducted, such as exploring differences between ethnicities, geographical locations, and age groups.

Glossary

Transgender: Transgender is a general term that refers to people whose gender identity differs from the gender they were assigned at birth according to their biological sex and the physiological characteristics of their bodies (Frediksen-Goldsen et al., p. 654; Budge, Adelson, & Howard, 2014). For example, a transgender woman is a person who was born with physiologically male characteristics but whose internal sense of self is female.

Biological sex: Biological sex is defined as anatomical, physiological, genetic, or physical attributes that determine if an individual is male, female, or intersex ("PFLAG National Glossary of Terms," 2019); sex and its relation to gender was influenced by psychologist John Money who, in the 1950s, identified biological factors, which included chromosomes, gonads, hormones, and internal and external genital morphology (Karkazis, 2019).

Transaffirmative: Transaffirmative is a non-pathologizing approach to treatment that accepts and validates all experiences of gender (Austin & Craig, 2015).

Transgender woman/Transgender man: A transgender woman is a person assigned male at birth, but identifies and expresses her gender as female. A transgender man is a person assigned female at birth, but identifies and expresses his gender as male (Trans Student Educational Resources, 2017).

MTF/FTM: MTF is male-to-female, which means individuals assigned biologically male characteristics at birth who have changed, are changing, or wish to change their body to a more feminine body. FTM is female-to-male, which means individuals assigned biologically female characteristics at birth who have changed, are

changing, or wish to change their body to a more masculine body. These terms can be offensive because they imply that an individual used to be male, for example, as opposed to being a woman or transgender woman who was assigned biologically male characteristics (Trans Student Educational Resources, 2017; APA, 2015).

Gender dysphoria: According to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; 2013), gender dysphoria refers to an individual's affective and cognitive discontent with the assigned gender and the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender.

Gender expansive: Describes individuals who view their gender identity as one of many possible genders beyond man or woman ("PFLAG National Glossary of Terms," 2019).

Nonbinary/third gender: Describes individuals who identify as neither man nor woman, both man and woman, or a combination of man or woman; who may understand the identity as being under the transgender umbrella, and who may identify as transgender ("PFLAG National Glossary of Terms," 2019).

Cisgender/cis: Cisgender/cis is defined as an individual who exclusively identifies as his/her sex assigned at birth.

Transphobia: Transphobia is defined as systemic violence against transgender people, associated with attitudes such as fear and distrust (Trans Student Educational Resources, 2017).

Anti-transgender prejudice: Anti-transgender prejudice denotes prejudice against transgender individuals and to acknowledge the prejudicial attitudes (rather than fear and phobia) that comprise this construct (Tebbe & Moradi, 2012).

Gender expression: External expression and communication of one's gender to the world (e.g., outward appearance, clothes, hair, mannerisms, voice; Gender Diversity, 2017).

Reflexivity Statement

In the scientific community, the training has not emphasized cisgender privilege introspection nor installed a process for rigorously speaking to the biases that come with the collective and prevalent cisgender lens (Galupo, 2017). As a cisgender individual, the researcher took her identity into consideration as an inherent source of bias and power differential. Her experience as a cisgender woman as she organized and conducted transgender-related research informed how she researched the topic, framed the research question and hypothesis, how she worded the initial screening, how she chose the measurement tools, what she decided to include in the weekly intervention curriculum, how she facilitated the degree to which transgender or gender nonconforming group participants shared certain experiences or the language they used to communicate their experiences (Galupo, 2017; Bender-Baird, 2008), and how she interpreted results of the study. The researcher did her best to remain objective and unbiased, and she assisted as needed when the group participants shared their stories and led the weekly discussions. Taking her identity into close consideration while in the group setting with the participants or alone while writing and revising her research manuscript, the researcher actively and sensitively acknowledged her "cis-ness" and intentionally engaged with trans perspectives (Galupo, 2017).

Specific Aims

The lesbian, gay, bisexual, transgender and queer (LGBTQ) population is three times more likely to struggle with a mental health condition, such as depression or anxiety (National Alliance on Mental Illness [NAMI], 2017), than the general population. This is due, in part, to deep-rooted prejudice and social stigma (Garnets, Herek, & Levy, 2003; Herek, 1998), which is also reflected in the historical practice of pathologizing and criminalizing this population (Fredriksen-Goldsen et al., 2014).

In 2013, with the publication of the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; 2013), the American Psychiatric Association (APA) reclassified "gender identity disorder" as "gender dysphoria." In so doing, they sought to depathologize transgender individuals by removing a diagnosis that is considered to be offensive and focusing more on the anxiety or discomfort the individual experiences. The clinical treatment is now focused upon distress caused by gender incongruence rather than the gender identity itself (Basu, 2012; Winters, 2012). Gender incongruence is defined as individuals' identities or behaviors that are not in line with their sex assigned at birth (Beek, Cohen-Kettenis & Kreukels, 2016). The clinical treatment is, therefore, geared toward depathologizing the transgender-lived experience (Austin & Craig, 2015). However, even with this new classification, transgender people continue to be stigmatized because "gender dysphoria" is still a classification of a mental condition, described as a, "clinically significant distress or impairment" (APA, 2013; Fredriksen-Goldsen et al., 2014). There is a risk indicating transgender people may use substances to self-medicate as a way to cope with gender dysphoria (Connolly and

Gilchrist, 2020). Moreover, pervasive transphobic discrimination and prejudice persist in pathologizing and stigmatizing the lived experience of transgender individuals.

In Fraser's (2009) study of this population, the researcher stressed that those who are developing a transgender identity must grapple with their body/mind mismatch. This self-identity is negatively impacted by social stigma (Fraser, 2009). One distinct developmental challenge that Fraser identified in this population is that transgender individuals are compelled to hide their transgender self from others. Thus, the transgender individual develops their identity secretly and alone. Even after "coming out" with their true identity, the individual often hides their identity later on—in essence returning to the "closet". Thus, psychological issues may begin to form early on in this population's development, which may prove to be a significant precursor for the development of future mental health issues, such as depression and anxiety.

Hoffman (2014b) found that transgender individuals are particularly vulnerable to mental health disparities. However, what Hoffman emphasized was the fact that this population must deal with the challenge of internal development, on the one hand, and societal intolerance and discrimination, on the other. Hoffman took this one step further, asserting that not only does depression affect their quality of life, but it is also linked to medical health problems (e.g., HIV/AIDS, cardiovascular and lung diseases), as well as to substance abuse and suicide. Researchers have also shown that major depressive disorder (MDD) and posttraumatic stress disorder (PTSD) are highly comorbid (Byllesby at al., 2017).

For the above reasons, it is imperative that health-care providers, whether they are providing mental health or medical care services to the transgender and gender

nonconforming (TGNC) population, be culturally sensitive and culturally responsible to understanding the needs of this vulnerable population (U.S. Department of Health and Human Services, 2012). An important first step would be to develop, implement, and assess transaffirmative interventions that address the mental health issues that this population is particularly susceptible to, such as depression. By adopting a transaffirmative approach to clinical practice, health-care providers are better able to identify the interpersonal, sociocultural, and political barriers to safety and quality of life experienced by transgender individuals and to effectively intervene upon these barriers (Austin & Craig, 2015). The current dissertation study was designed to assess the effectiveness of one such intervention. The particular intervention under investigation was a group-based intervention that had been developed for treating depression in transgender individuals, most of whom identified as transgender women, using cognitive behavioral therapy (CBT). The researcher proposed to assess the effectiveness of this intervention by implementing it with a group of mostly transgender women diagnosed with depression. This 5-week therapy group was followed with one final session 1 month after the intervention had been completed.

The researcher hypothesized that participating in this intervention would result in a clinically significant reduction in depressive symptoms among the participants. The participants were given a series of measures, before, midway through, and after the 5-week group therapy intervention, to measure the results, and in particular, of any change in the level of depression.

Twenty-three adult transgender individuals, most of whom identified as transwomen, were recruited through several organizations serving the LGBTQ

community in the San Francisco Bay Area, including the San Francisco Community Health Center, Trans:Thrive and Trans Access. As part of the recruitment process, health-care professionals at these organizations referred individuals, who met the inclusion criteria for participation in the study, to this researcher. Inclusion criteria for this study included: participants must be 18 years or older, self-identify as a transgender woman, and have experienced mild, moderate, or severe depressive symptoms for at least 2 weeks as indicated by the DSM-5.

The current study aligned with the University of San Francisco Jesuit social justice mission to honor and promote the dignity of every person and empower the voices of the underserved, disadvantaged, and poor, as well as the core value of the Jesuit tradition to "care for the whole person" (University of San Francisco, n.d.). This particular study brought together a group of transgender individuals, most of whom identified as female, suffering from depression who were able to share their stories in a safe and supportive environment. Through the intervention model, these individuals learned coping skills and improved the quality of their lives by decreasing their level of depression.

CHAPTER I

Introduction to the Study

The Challenges of the LGBTQ Population

Approximately 9 million (3.5%) adults in the United States self-identify as lesbian, gay, or bisexual (LGB; Gates, 2011). The number of those who self-identify as transgender is much lower: approximately 1 million (0.3%; Fredriksen-Goldsen et al., 2014). However, researchers believe that this latter statistic is underestimated as those who self-identify as transgender often choose to not disclose their gender identity to others for fear that they will be discriminated against, stigmatized, publicly humiliated, marginalized, forced into isolation, or be subjected to assault (Borden, 2015; National Alliance on Mental Illness [NAMI], 2017).

The challenges of the LGBTQ population are greater in many ways than the general population due to the stigma and discrimination they are subjected to by the general population. Because of these societal prejudices, the transgender and gender nonconforming (TGNC) population experiences challenges in achieving social, psychological, and economic stability (Grant, Mottet, Tanis, Harrison, Herman, & Keisling, 2011). Grant and colleagues' (2011) study examined some of these challenges. In particular, the researchers focused on education, employment, health, family life, housing and homelessness, public accommodations, identity documents, and experiences with police and incarceration. The researchers surveyed 6,450 transgender and gender-nonconforming individuals. The researchers' findings were highly concerning. They concluded that transgender bias, combined with persistent, structural racism, negatively impacts the quality of life of transgender individuals in three significant areas:

psychological, social, and financial. A full 63% of these participants reported that they had experienced a significant act of discrimination due to gender identity and expression. These significant acts of discrimination included loss of employment, eviction, bullying and harassment in school, physical and/or sexual assault, denial of medical services, homelessness, incarceration, and loss of relationships. In addition, approximately 23% reported that they had experienced three or more of these acts of discrimination at the same time.

Transgender and gender nonconforming (TGNC) people of color fare even worse in all areas, including greater levels of unemployment, harassment by police, and refusal of medical care than their White transgender counterparts (Grant et al., 2011). Of this subgroup, African American transgender individuals are the most oppressed (Grant et al., 2011). Further, transgender and gender-nonconforming people of color are more likely to live in extreme poverty (Grant et al., 2011). Finally, and perhaps most concerning of all, Grant and colleagues (2011) found that a staggering 41% of their TGNC participant pool reported having attempted suicide (compared to 1.6% of the general population). Taken as a whole, the researchers concluded that these results indicate a moral failure, not only of society's unwillingness to embrace different gender identities and expressions, but perhaps even more egregious, placing the blame on transgender and gender-nonconforming people for having "brought the discrimination and violence upon themselves" (Grant et al., 2011).

The lesbian, gay, bisexual, transgender and queer (LGBTQ) population is 3 times more likely to struggle with a mental health condition, such as depression or anxiety (National Alliance on Mental Illness [NAMI], 2017), than the general population. This

statistic is particularly alarming given that the number of individuals in the general population who suffer from mental illness is already significant: about 43.8 million adults in the US in any given year. In 2015, approximately 16.1 million adults had at least one major depressive episode (National Institutes of Mental Health [NIMH], 2017).

Researchers have concluded that the added social challenges of identifying as transgender increases the risk of mental illness (Fredriksen-Goldsen et al., 2014; National Institutes of Health [NIH], 2010; U.S. Department of Health and Human Services, 2010). Mental illnesses that have been associated with transgender individuals include depression, anxiety, posttraumatic stress disorder (PTSD), suicidal ideation, and substance abuse (NAMI, 2017). Specifically, with transgender women, researchers have found that as many as 62% have reported a lifetime of depressive symptoms (Hoffman, 2014). Yet, coupled with these sobering statistics, many transgender individuals, when sick or injured, postpone or do not seek out mental health services due to insensitivity of health-care providers, discrimination, or inability to afford care, which undoubtedly prevents them from enjoying a fuller quality of life and a greater sense of well-being (Bockting, Miner, Romine, Hamilton, & Coleman, 2013; Grant et al., 2010; Shipherd, Green, & Abramovitz, 2010).

The most common medical conditions identified in the transgender population are the human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS). According to the National Transgender Discrimination Survey conducted in 2011 (NTDS, 2011), transgender individuals reported over 4 times the national average of HIV infection, with rates higher among transgender individuals of color (Grant, Mottet, & Tanis, 2011). In a 3-year study, Nuttbrock and colleagues (2013) found

correlations between gender abuse and depression and risk factors for acquiring HIV and other sexually-transmitted infections (HIV/STI). Nuttbrock et al. (2014a) also found age to be a significant variable. That is, older transgender women tend to be less vulnerable to gender abuse, specific to transgender people, because they have become more psychologically resilient; younger transgender women, however, remain psychologically vulnerable to gender abuse. The data suggest that this greater susceptibility to gender abuse increases the likelihood that younger transgender women will engage in high-risk sexual behaviors, which most often lead to HIV/STI infections. The study also revealed a greater association between transgender women and unprotected receptive anal intercourse (URAI)—regardless of whether the sexual behavior was engaged in with a committed partner, casual acquaintance, or for commercial purposes. Moreover, URAI also often leads to HIV/STI infections (Nuttbrock et al., 2013).

Research that will guide mental health professionals and other professionals who work with the TGNC population to provide effective, more informed treatment for this population is inadequate, at best, and greatly needed. The current study aimed to address this gap in the literature. This researcher hoped that this study would allow mental health and other professionals that work with this population to better understand and become culturally-sensitive and culturally responsible to the needs of the transgender and gender nonconforming population by adopting a transaffirming approach to treatment.

Cognitive Behavioral Therapy

Cognitive behavioral therapy (CBT) is an evidenced-based intervention based on the rationale that an individual's experience, emotions, and behavior are based on their perceptions, as well as the structure, of their experiences (Beck at al., 1991). In other

words, people's perceptions of their experience are more closely related to their reaction than the actual experience or situation itself. One of the primary goals of CBT is to help clients change their negative thinking (e.g., cognitive distortions). The theory holds that maladaptive behaviors and emotions are formed out of an individual's interpretation of his or her experiences. Further, these interpretations are informed by their core beliefs (Beck et al., 1991; Beck Institute of Cognitive Behavior Therapy, 2016).

This researcher investigated an intervention designed for transgender individuals who are suffering from depression. The intervention itself was a 5-week group-based therapy that utilized a CBT model. This researcher evaluated the effectiveness of this intervention using pre-, mid-, and posttests to determine whether the level of depression of the transgender individuals in the study had decreased. In addition, this study assessed the feasibility of a pilot intervention using a culturally adapted treatment for adult transgender individuals suffering with depression.

CHAPTER II

The Review of the Literature

Researchers have concluded that the added social challenges of identifying as transgender increases the risk of mental illness (Fredriksen-Goldsen et al., 2014; National Institutes of Health [NIH], 2010; U.S. Department of Health and Human Services, 2010). As a result of socio-economic marginalization, transgender individuals experience higher rates of HIV infection, drug and alcohol use, and suicide attempts than the general population (Grant et al., 2011). Mental health issues most commonly found amongst transgender individuals include depression, anxiety, posttraumatic stress disorder (PTSD), suicidal ideation, substance abuse (NAMI, 2017), and gender dysphoria (American Psychiatric Association & DSM-5 Task Force, 2013; Fredriksen-Goldsen et al., 2014). Male-to-female transgender individuals also may engage in behaviors that put them at risk for human immunodeficiency virus (HIV; Clements-Nolle, Marx, Guzman, & Katz, 2001), and studies have revealed a high prevalence of HIV among male-to-female sex workers from Atlanta, Georgia; Tel Aviv, Israel; and Rome, Italy. Clements-Nolle and colleagues (2001) conducted one of the largest quantitative studies to describe HIV risk of transgender individuals in San Francisco, California, and found that male-to-female transgender individuals were more socioeconomically disadvantaged and had higher HIV prevalence.

Depression and Anxiety

Transgender individuals report higher levels of elevated symptoms of depression and anxiety due to psychological distress than the general population (Budge, Adelson & Howard, 2013). In spite of the high comorbidity between depression and anxiety, both

common mental health complaints among the transgender population, little is known about how to best work with these mental health concerns using transaffirmative interventions. The prevalence rates of depression among the transgender population are especially concerning, as they range from 44%–62% (Bockting, Miner, Romine, Hamilton, & Coleman, 2013; Nemoto, Bodeker, & Iwamoto, 2011). Researchers have found that transgender individuals who have no family support are at even greater risks for high levels of depression (nearly 6 times greater); moreover, this population is 8 times more likely to have attempted suicide (Shipherd, Green, & Abramovitz, 2010). With transgender women, in particular, the rates of depression are higher than the general population, with a lifetime prevalence of depression as high as 62% above the general population (Hoffman, 2014). The prevalence of anxiety disorders is also high among the transgender population, ranging from 33.2%–47.5% (Bockting at al., 2013; Budge, Rossman, & Howard, 2014). However, despite these staggering statistics, the transgender population has difficulty accessing treatment (Bockting et al., 2013). According to Grant et al. (2011), 19% of the sample study reported being refused medical care due to their transgender status.

Substance Use

The transgender population is also at a higher risk for substance use when compared to the cisgender population. Nuttbrock and colleagues (2014b) conducted a 3-year prospective study (December 2004 to September 2007) of 230 transgender women from the New York Metropolitan Area and over a 6-month period, the researchers concentrated on substance use. They found that the prevalence of substance use in this population was as follows: 60.4% for heavy alcohol, 40.0% for marijuana, 21.7% for

cocaine, 3.9% for stimulants, and 3.5% for opiates. Nuttbrock and colleagues (2014b) found that the prevalence of substance use was exceedingly high in transgender women: in particular, more than three fourths were using alcohol or other substances, and approximately one third reported polysubstance use. Other researchers, including Nuttbrock et al. (2014a), have found that depressive symptoms often increase the moderately strong associations between gender abuse (e.g., enacted stigma or discrimination) and substance use. That is, when the victim is also suffering from depression, they are more likely to turn to substance use for self-medicating purposes. However, further research is needed to better understand the correlation between gender abuse and substance use among transgender women (Keuroghlian, Reisner, White & Weiss, 2015; Nuttbrock et al., 2014b).

Gender Dysphoria

With the publication of the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; 2013), the American Psychiatric Association (APA) reclassified "gender identity disorder" as "gender dysphoria." In so doing, they aimed to depathologize transgender individuals by removing the diagnosis that is considered to be offensive and focusing more on the anxiety or discomfort the individual experiences. Currently, clinical treatment is focused upon distress caused by gender incongruence rather than the gender identity itself (Basu, 2012; Winters, 2012). However, even with this new classification, transgender people continue to be stigmatized because "gender dysphoria" is still a classification of a mental condition, described as a, "clinically significant distress or impairment" (APA, 2013; Fredriksen-Goldsen et al., 2014).

In their study of transgender individuals, Shiffman and colleagues (2015) found that the rates of gender dysphoria are as high as 45%. Although it is hoped that the *DSM-5*'s reclassification will ameliorate the situation, still, pervasive discrimination and prejudice persist. Consequently, transgender individuals who are developing their transgender identity are still subjected to being pathologized and stigmatized by the population at large (Fraser, 2009). According to Budge, Katz-Wise, Tebbe, Howard, Schneider, and Rodriguez (2013), the high visibility of transgender individuals in the communities in which they live places them in a more susceptible position to experience gender-based discrimination, victimization and violence.

HIV and AIDS

Grant and colleagues (2011) found respondents from their survey reported over four times (38%) the national average of HIV infection, with higher rates among transgender people of color. Clements-Nolle and colleagues (2001) reported their estimate of HIV prevalence among male-to-female transgender individuals was higher than estimates from studies with gay men and injection drug users of the same age in San Francisco, California. In their study, half of the male-to-female transgender individuals who were HIV positive did not receive medical treatment for HIV, and many of them, who tested positive for HIV, thought they were not infected. This finding emphasizes the importance of counseling transgender individuals about HIV and early intervention (Clements-Nolle et al., 2001).

Grant and colleagues (2011) reported that in the face of employment discrimination, sixteen percent (16%) of survey respondents enter the underground economy for survival, as sex workers or by selling drugs. Transgender respondents of

color were more likely to have reported engaging in sex work (e.g., African-Americans at the highest rate, 44%. Latino/a, 28%), and for those who engaged in sex work, they were over 25 times more likely to be HIV-positive (15.32%) than the general population (0.6%; Grant et al., 2011).

The prevalence of HIV is higher among transgender women than the general population, with self-reported prevalence rates as high as 19%–32% (Hoffman, 2014). There are four primary risk factors associated with acquiring HIV in the transgender population. These risk factors are (a) having multiple sex partners (31.7%), (b) having sex with partners who inject drugs (24.3%), (c) having HIV-seropositive sex partners (44.1%), and (d) engaging in sex work or having sex with primary partners who engage in sex work (Feldman et al., 2014). Notably, there is a higher prevalence of drug use, HIV, and sex work in transgender women than the general population (Hoffman, 2014). Transgender individuals, in general, undergo considerable psychological distress that often leads to depression, especially when combining medical conditions, such as HIV and AIDS, with cumulative experiences of discrimination, victimization, and microaggressions.

Protective and Risk Factors

Both protective and risk factors have been identified in the literature for depression, anxiety, suicidality, gender dysphoria, and substance use. Many of these conditions can co-occur or overlap, especially among transgender individuals who often experience several of these risk factors simultaneously. Yet, few studies have been conducted with the transgender population that focus on the protective and risk factors associated with mental health. This is an egregious oversight as this is a vulnerable

population that suffers from social isolation and lack of overall social support (Rotondi et al., 2011).

Protective factors. Protective factors are defined as aspects of a person's life that help build resiliency and reduce vulnerability to risks (Whiting, Boone, & Cohn, 2012). Prominent among these protective factors are strong social support, family acceptance, and individual acceptance. Family acceptance is especially significant for adolescents, and it has also been found to be an indicator of well-being among young transgender people (Snapp, Watson, Russell, Diaz, & Ryan, 2015). Whiting, Boone, and Cohn (2012) also found that adolescents who receive parental acceptance and support are less likely to become depressed or suicidal, run away, or engage in risky behaviors.

Another important positive association has been found between acceptance and social support in protecting against mental illness. This was also found to be the case within the transgender population, as those who are accepted by their social group report higher self-esteem (Snapp et al., 2015), which is also a protective factor against mental illness. Another protective factor includes a strong social support network, which has been shown to protect against depression among this population (Rotondi et al., 2011).

Social support from friends is another important protective factor, which has also been shown to be correlative with one's well-being. Snapp et al. (2015) also found being in peer-based groups with other transgender individuals to be a protective factor. This dissertation study addressed this latter supportive factor in that the CBT group therapy intervention created a nonstigmatizing environment of safety and care for the transgender participants.

Many factors impact one's self-acceptance; however, one important aspect of self-acceptance is the realization and acceptance of one's gender. Not surprising, then, people who accept their identification as a transgender person and learn to comfortably express their gender identity show improvements in their overall well-being (Moody, Pelaez, Fuks, & Smith, 2015). Moody et al. (2015) emphasized that after one realizes that one is transgender, it is important to develop comfort with that identity. Moody et al. also equated self-acceptance with the importance of being accepted by family, friends, and peers. Finally, Moody et al. found that those with the highest level of well-being were able to become the person they were meant to be.

Crenshaw's (1991) theory of intersectionality examined how the experiences of women of color are the product of racism and sexism. Women of color embody intersectional identities as both woman and of color within discourses that are formed to respond to one or the other, thus women of color are marginalized against both gender and race. Based on Crenshaw's theory, transgender women of color face multiple marginalizations, according to Jefferson, Neilands and Sevelius (2014). Jefferson et al. (2014) pointed out that although transgender women of color share transphobic experiences with other transgender individuals, share experiences of sexism with other women and transwomen, and share experiences of racism with people of color, transgender women of color face increased discrimination due to being marginalized in multiple ways. As a result of intersectionality, transgender women of color experience complex psychological distress that often leads to depressive symptomatology (Jefferson et al., 2014).

Risk factors. As has been noted above, there are many risk factors for this population. Risk factors are defined as attributes or exposures of an individual that increase the probability of developing a disease or injury (WHO, 2017). The risk factors for this population include transphobia, social isolation and family rejection, medical transition, and gender abuse (Borden, 2015; Nuttbrock et al., 2014; Rotondi, Bauer, Scanlon, Kaay, Travers, & Travers, 2011; Yadegarfard, Meinhold-Bergmann, & Ho, 2014). Each of these risk factors is discussed here.

Transphobia. Transgender people often experience isolation, discrimination, and humiliation due to transphobia (Borden, 2015). A study by Rotondi and colleagues (2011) found a high correlation between stress and experiences of discrimination, stigmatization, and victimization due to one's gender identity. This stress, in turn, is positively associated with mental health issues among transgender people. (Borden, 2015; Grant et al., 2011). Moreover, the effects of transphobia often manifest on a very basic quality-of-life level as it may interfere with their ability to secure housing, employment, and financial stability. Transphobia has also been tied to numerous negative outcomes, including bullying and harassment in college, physical and/or sexual assault, denial of medical services, homelessness, and incarceration (Borden, 2015).

Social isolation and family rejection. Social isolation and rejection from family, friends, and society at large are significant risk factors for the transgender population (Yadegarfard, Meinhold-Bergmann, & Ho, 2014). A notable correlation was found in the study by Yadegarfard and colleagues (2014) between family rejection and depression. The researchers found that family rejection was a significant predictor of the transgender individual's level of depression, as well as various risk behaviors. This area of risk is

significant for the transgender population, as they generally face more rejection from family than the nontransgender or cisgender population. Further, rejection and lack of social support generally lead to social isolation for transgender individuals. Rejection has many forms, including discrimination and enacted stigma or gender abuse by loved ones and society (Yadagarfard et al., 2014). In addition to a greater risk for depression, these risk factors also increase the likelihood of other mental health issues, including anxiety, substance abuse, sexually risky behavior, and suicidal ideation. In a study conducted by Clements-Nolle, Marx, and Katz (2006), the authors confirmed the significance of not only individual risk factors such as history of sexual trauma, substance abuse, and depression, but also of societal risk factors such as gender-based discrimination and victimization that are independently associated with attempted suicide.

Medical transition. Another risk factor for depression is when an individual desires but is not able to undergo the medical transition that they desire to physically transition to the identified sex. Conversely, individuals who have already begun the transition process or have already transitioned have a lower risk of developing mental illness. Rotondi et al. (2011) posited that this may be due to a reduction in depression and anxiety associated with the dysphoria. Not all transgender and gender nonconforming individuals wish to undergo medical transition (Austin, Craig, & Alessi, 2017).

Gender abuse. Gender abuse, specific to transgender people, is defined as enacted stigma or discrimination or forms of psychological or physical abuse by others (Nuttbrock et al., 2014). In their 3-year prospective study, Nuttbrock et al. found that gender abuse is a risk factor for an array of interrelated adverse health outcomes, and they

found moderately strong correlations between gender abuse and an individual's turning to substance use as a means for self-medicating depressive symptoms.

Transgender-Affirmative Cognitive Behavioral Therapy (TA-CBT)

Recently, Austin and Craig (2015) developed the transgender-affirmative cognitive behavioral therapy method (TA-CBT; see Appendix A). TA-CBT is a culturally adapted, nonpathologizing intervention designed for clinicians working with transgender individuals who are suffering from mental health conditions (e.g., depression, anxiety, suicidality, feelings of shame, low self-esteem, and powerlessness). Many of these mental health complaints stem from being subjected to relentless prejudice and discrimination, which this population experiences in their daily lives in the form of harassment, violence, and microaggressions (Austin & Craig, 2015).

The TA-CBT method focuses on the client learning how to identify, evaluate, and then change maladaptive thoughts and behaviors. The transgender population is especially vulnerable to adapting negative patterns because they have been consistently exposed to transphobic attitudes, beliefs, and behaviors (Austin & Craig, 2015). This type of negative exposure often causes individuals to develop a negative pattern of thinking about themselves and their future, which has a direct impact on their mental health and their behaviors (Austin & Craig, 2015).

The TA-CBT approach has six primary components: (a) the orienting framework of a transaffirmative practice and minority stress model, (b) understanding resilience among transgender individuals, (c) psychoeducation, (d) challenging transgender individuals' negative self-beliefs, (e) modifying cognitive cycles of hopelessness that

often lead to suicidality, and (f) encouraging social connectedness. This approach can be completed in eight sessions.

The TA-CBT has several strengths. First, it provides a transaffirmative and culturally sensitive approach to treating the transgender population. Second, it addresses stressors associated with mental health issues often experienced among minority clients. This particular therapy method also acknowledges and takes into consideration the oppressive contexts within which transgender clients generally experience health care, and it then strives to counter these contexts. The TA-CBT, however, has one significant weakness, which is that no published efficacy data exist. This is no doubt due, in part, because the test was only developed in 2015, less than 5 years from when this current study was conducted.

Another important feature of the TA-CBT intervention is that it provides the clinician with the preferred terminology of the transpopulation, as well as providing guidance on how best to communicate with this population using language that is transaffirmative, gender-neutral, and inclusive of all gender perspectives. This language also helps the provider to clarify his or her role and the purpose of the therapeutic relationship, and finally, to engage with sensitivity and understanding (Austin & Craig, 2015).

The TA-CBT intervention incorporates the minority stress model (Meyer, 2003). This model has increasingly being used among the Lesbian, Gay, Bisexual, Questioning/Queer, and Transgender population to acknowledge and inform the transgender clients of the increased risks for negative outcomes and maladaptive behaviors (Austin & Craig, 2015; Austin, Craig, & Alessi, 2017). For example,

transgender clients may experience chronic stress because they are repeatedly subjected to prejudicial encounters. At the same time, this external experience and these stressors are perpetuated by internal conflict, resulting in a constant pressure between one's internal self and the expectations of one's social, cultural, and political environments. The TA-CBT helps to contextualize these stressors for transgender clients.

Both individual and social stressors have been identified in the TA-CBT method (Meyer, 2003). Individual stressors, described as personal events and conditions that precipitate change, require the individual to adapt to a new stressful situation (Meyer, 2003). Social stressors, described as conditions in the social environment that may induce psychological distress and physical ills, often negatively impact the lived experiences of individuals who identify with socially stigmatized groups. These groups may be characterized by socioeconomic status, race/ethnicity, gender, or sexuality (Meyer, 2003).

Resilience is another critical component in the treatment. By teaching resilience to transgender clients, it helps to support their evolving self-generated definition of self and self-worth and cultivates hope while, at the same time, increases their awareness of the oppression they are exposed to in their daily lives. Resilience is often developed by engendering hope, connecting with a supportive community, engaging in social activism, and becoming a positive role model (Austin & Craig, 2015).

The third component of TA-CBT is psychoeducation. This is also critical to creating a safe, transaffirmative environment in which a client's experiences with discrimination, harassment, microaggressions, and violence can be voiced, acknowledged, and validated. The last three components of this intervention include challenging transphobic negative self-beliefs, helping change cognitive cycles that

promote hopelessness (primary predictor of suicide), and finally, encouraging transaffirming social connectedness and a sense of belonging (Austin & Craig, 2015).

Mental health professionals and medical professionals should show gender inclusivity at first contact with transclients, they should create policies in regard to access to care and services based on gender identity, they should develop transgender-inclusive informational pamphlets and web-based related materials, and they use gender inclusive language on clinical intake forms (Austin, Craig, & Alessi, 2017).

In a pilot study of a psychotherapy process group for transgender individuals, the researchers pointed out the importance of group facilitators being aware of their own gender identities, as well as their beliefs and biases about gender, and how being unaware of transgender issues could impact group process (Heck, Croot, & Robohm, 2015).

As noted earlier, the literature has established that there is a high prevalence of depression, impacted by both mental health and medical conditions (e.g., anxiety, substance use, gender dysphoria, HIV and AIDS), among the LGBTQ population. In a recent pilot study, Craig and Austin (2016) examined the effectiveness of an affirmative cognitive behavioral coping skills group intervention (AFFIRM) with a diverse sample of sexual and gender minority youth (n=30). The group participants completed measures for depression, reflective coping and stress appraisal. Not only did the researchers' findings indicate a notable decrease in depression and reduction in appraising stress as a threat but also a notable increase in reflective coping and perceiving stress as a challenge (Craig & Austin, 2016). The researchers also reported that the youths found the intervention to be acceptable and gained valuable skills from engaging in AFFIRM, especially through the lens of CBT in connecting their thoughts, feelings, and behaviors (Craig & Austin, 2016).

The pilot study's findings support the utilization of affirmative CBT with sexual and gender minority youth and proposes that other evidence-based treatments could be adapted to include affirmative approaches for this youth population. However, in regards to the adult transgender population, little is known about how to effectively treat depressive symptoms using transaffirmative interventions. Thus, this study offered a first step in meeting this need by investigating the effectiveness of a group-based intervention using a transaffirmative CBT modality to treat adult transgender individuals suffering from depression.

Research Question and Hypothesis

Driving this research study was the question: Is a transaffirmative, group-based, CBT intervention effective in treating symptoms of depression among transgender individuals, as measured by the Patient Health Questionnaire Somatic, Anxiety, and Depressive Symptoms Scales (PHQ–SADS)?

The PHQ–SADS is a screening instrument that assesses the common co-occurrence of somatization, anxiety, and depression (Spitzer, Williams, & Kroenke, 2010). The instrument comprises the PHQ–9 (9-item depression scale), the GAD–7 (7-item anxiety scale), the PHQ–15 (15-item physical symptom scale), and questions about panic symptoms. Kroenke and colleagues (2010) reported that the PHQ–9, GAD–7, and PHQ–15 are well-validated measures for detecting and monitoring depression, anxiety and somatization.

The researcher hypothesized that participation in this intervention would result in a clinically significant reduction in depressive symptomatology among the participants.

Significance/Proposed Impact

The significance of this dissertation study was that it would be one of the first studies to investigate the effectiveness of a transaffirmative, group-based, CBT intervention for treating mostly transgender women suffering from depression. The impact of the study would be to provide validity to this intervention; specifically, a group-based therapy designed for six to eight transgender participants, using an affirmative-based CBT modality. The group met weekly for 5 weeks, each time for 2 hours. They then met one last time for a booster session 1 month after the end of the last group therapy session. The study showed that this intervention was effective in significantly reducing the depressive symptoms among the group members.

Additionally, this study supported the University of San Francisco Jesuit social justice mission to honor and promote the dignity of every person, as this study increased our awareness of this underserved and stigmatized population by empowering their voices in the spirit of advocating for the human rights and psychological well-being of all people. This study also took into account a core value of the Jesuit tradition to "care for the whole person" (University of San Francisco, n.d.). The group dynamic of bringing together a group of transgender individuals who have been subjected to prejudice, stigma, and microaggressions—and even traumatized—by a stigmatizing and prejudicial society allowed them to share their stories within a safe and supportive community, learn coping skills, and lift themselves up from their depressive symptoms.

CHAPTER III

Methods

This dissertation study was designed to assess the effectiveness of a 5-week, group-based intervention using cognitive behavioral therapy (CBT) developed for treating depression in transgender people. To assess this intervention, the researcher conducted three groups comprised of transgender individuals, most of whom identified as transgender women, who had been diagnosed with depression. The intervention included five sessions plus a follow-up booster session 1 month after the group had been completed. At three time points—before the group began, midway through the group, and 1 month after the group had been completed (the booster session)—the participants were given a series of measures to assess whether any change in their level of depression had occurred. The study implemented a pre-post, group therapy intervention effectiveness study. A one-way within subjects (or repeated measures) ANOVA (ANOVA; Field, 2016) was conducted to compare the effect of time on depressive symptoms. Additionally, a paired samples t-test (Laerd Statistics, 2018), which compared the mean scores of depressive symptoms, was conducted.

IRB Approval

The research study presented in this dissertation was approved by The University of San Francisco (USF) Institutional Review Board (IRB).

Participants

For the current study, the initial goal was to recruit between 18-24 participants. The total number of participants, who were recruited and screened, was 23 adults, who self-identified as transgender, were above 18 years old, and had mild, moderate, or severe

depression symptoms. They were recruited for the study from three organizations serving the LGBTQ+ community in the San Francisco Bay Area: the San Francisco Community Health Center (SFCHC), Trans: Thrive, and Trans Access. Participants were also recruited through recruitment flyers and word-of-mouth. Twenty-one of them completed informed consent, and overall, 14 transgender individuals engaged in the intervention that took place at the San Francisco Community Health Center.

Inclusion and Exclusion Criteria

In order to qualify for the study, participants needed to meet the following criteria: (a) identified as a transgender woman; (b) were 18 years or older; and (c) had mild, moderate, or severe depressive symptoms. In order to determine the latter criterion, the interested participants were administered the Patient Health Questionnaire (PHQ–9; Kroenke, Spitzer, & Williams, 2001) to screen for and measure the severity of their depression, which is defined by the *Diagnostic & Statistical Manual of Mental Disorders (DSM-5*; American Psychiatric Association [APA], 2013) as experiencing of mild, moderate, or severe depressive symptoms for at least 2 weeks. Those meeting criteria for depressive symptoms, based on the PHQ–9, qualified for participation in the study. The following were the exclusion criteria or conditions: (a) did not identify as a transgender woman; (b) did not have mild, moderate, or severe depressive symptoms; (c) showed evidence of an active psychosis that was not being managed; and (d) did not speak English.

From the start of recruitment, potential participants were asked if they identified as a transgender woman. The transgender clients, who confirmed they identified as a transgender woman and were 18 years or older, were asked to participate in a screening

to see if they met the last criterion for mild, moderate, or severe depressive symptoms. If the potential participant met all inclusion criteria, then they signed a consent form, and completed the Trauma Health Questionnaire (THQ), as well as the Demographic Questionnaire. There were two participants who verbally indicated they identified as a transgender woman; however, it was later discovered that these two individuals upon answering the question about gender identity on the Demographic Questionnaire did not identify their gender as female. One participant identified their gender as non-binary/third gender and the other participant preferred not to say.

Setting

The San Francisco Community Health Center (SFCHC) is an interdisciplinary health-care organization for the LGBTQ community and people of color. SFCHC is a Federally Qualified Health Center that provides primary care services in underserved areas and on a sliding fee scale, and it typically serves homeless and marginally housed clients, survivors of trauma, immigrants and refugees, as well as marginalized populations that often struggle to engage in care. SFCHC offers mental health services, case management, HIV care and prevention services, HIV and STD testing and health education, as well as other supportive services for the transgender population. SFCHC collaborates with Trans: Thrive and Trans Access and also shares its nonstigmatizing setting with them. SFCHC also collaborates with social workers, case managers, and care navigators. Trans: Thrive provides an array of transgender health and community services, including workshops, support groups, needle exchange, mental health and substance use counseling, case management, and medical care. Trans Access provides an open access medical clinic serving trans women of color living with HIV, including

primary and HIV care, hormone replacement therapy, case management, peer navigation, and social support.

Description of Measures

The following measures were used in this study: the demographic questionnaire, the Patient Health Questionnaire–9 (PHQ–9), the Trauma History Questionnaire (THQ), the Patient Health Questionnaire–SADS (PHQ–SADS), the Alcohol Use Disorders Identification Test-C (AUDIT–C), the Drug Abuse Screening Test–10 (DAST–10), and the Group Satisfaction Scale (GSS). The PHQ–9 and the THQ were used as screening measures in this study, whereas the PHQ–SADS, AUDIT–C, DAST–10, and the GSS were used to evaluate the intervention. These measures are presented here.

Demographic questionnaire. All participants completed a demographic questionnaire, which included identifying questions about their (a) age, (b) gender, (c) race/ethnicity, (d) employment status, (e) relationship status, and (f) HIV/AIDS status. Employment status was included because the ability to support and sustain one's financial and emotional well-being impacts one's quality of life (Grant et al., 2011). Obtaining the participants' employment, relationship, and HIV/AIDS status were important as they helped inform the researcher of the protective and/or risk factors that impact one's level discrimination. (See Appendix B for a copy of the demographic questionnaire.)

Screening Measures

The PHQ–9 and the THQ were used as screening measures in this study.

Patient Health Questionnaire (PHQ–9). The Patient Health Questionnaire (PHQ–9; Kroenke, Spitzer, & Williams, 2001) was utilized in this study as a standard

screening measure for depression. The PHQ–9 is a self-report measure with nine items that assess and monitor depression severity. The measure is used to diagnose major depressive disorder (MDD; Kroenke, Spitzer, Williams, & Löwe, 2010), and it can also be used as an ongoing screening tool, with scores ranging from 0 to 27, measuring the severity levels of depressive symptoms, as follows: 0-4 = *minimal*, 5–9 = *mild*, 10-14 = *moderate*, 15-19 = *moderately severe*, and 20-27 = *severe* (Kroenke et al., 2001). In this questionnaire, individuals are asked to identify the extent to which they have been bothered by depressive symptoms over the last 2 weeks, using a Likert scale: 0 = *not at all*, 1 = *several days,* 2 = *more than half the days*, and 3 = *nearly every day.*

The PHQ–9 scale has a number of strengths. First, its diagnostic reliability and validity were established by two original studies involving 6,000 patients (n = 3,000 primary care patients and n = 3,000 obstetrics-gynecology patients). These studies provided strong evidence to validate the test's ability to measure depression severity. In these two large-scale studies, similar results were obtained with different patient populations, thus indicating that the PHQ–9 is generalizable to patients within a variety of clinical settings.

The PHQ–9 is equally valid whether test-takers are asked to fill out the test by themselves (self-report) or whether it is administered by an interviewer in person or over the phone. The test has also been found to be valid across the variables of sex, age, and racial/ethnic groups (Kroenke et al., 2010). Kroenke and colleagues (2010) also noted that the PHQ–9 has been adopted as a standard screening measure for depression by many organizations, including the Veterans Administration, U.S. Department of Defense,

and Kaiser Permanente, as well as a number of integrated health-care systems, managed behavioral care organizations, and public health departments.

The PHQ–9 scale has also been used clinically across an array of medical conditions, including neurological disorders, cardiovascular disease, HIV, diabetes, cancer, gastrointestinal disease, dermatological disorders, ophthalmologic and otolaryngology disorders, pain and other somatic symptoms, and brain and spinal cord injury, in addition to various medical conditions that arise within obstetrics-gynecology practices (Kroenke et al., 2010). The PHQ scales have been translated into more than 60 languages, which broadens the scale's efficacy in studying mental health disorders and improving clinical outcomes globally (Kroenke et al., 2010). However, in light of all of the above strengths, one group of researchers asserted that the measure does not wholly take into account cultural differences (Kalibatseva, Leong, & Ham, 2014). Kalibatseva et al. (2014) argued that there is ample evidence to show that cultural differences impact how an individual communicates and experiences psychological distress, such as depression and anxiety. For example, people of Asian descent may tend to communicate and experience depression in the form of somatic symptoms (Kalibatseva et al., 2014). The researchers concluded that unless cultural differences are taken into consideration and the screening tool is culturally adapted accordingly, the PHQ–9 scale would not be an effective measure for depression in all populations. (See Appendix C for a copy of this instrument.)

Trauma History Questionnaire (THQ). The Trauma History Questionnaire (THQ; Hooper et al., 2011) was used in this study in the screening process to determine the potential participants' experience of traumatic events. THQ is a 24-item self-report

instrument using a yes/no format that asks the respondent to identify experiences with potentially traumatic events, such as crime, natural disasters, and sexual and physical assault. Because the THQ is a data collection instrument and not a test, no standard scoring method exists (Hooper, Stockton, Krupnick, & Green, 2011). For each endorsed event, respondents are asked to provide the frequency as well as their age at the time of the event (U.S. Department of Veterans Affairs, 2016). The THQ has been used in many clinical research studies to identify traumatic life experiences and to analyze the relationship between traumatic life experiences and medical conditions, psychological distress, mental illness, and substance use disorders (Hooper et al., 2011). Preliminary evidence shows that the THQ is reliable and valid in both clinical and nonclinical samples (Hooper et al., 2011). (See Appendix D for a copy of this instrument.)

Intervention Measures

The PHQ-SADS, AUDIT-C, DAST-10, and the GSS were used in this study to evaluate the intervention.

The Patient Health Questionnaire: Somatic, Anxiety, and Depressive Symptoms (PHQ–SADS). The Patient Health Questionnaire–SADS (PHQ–SADS; Spitzer, Williams, & Kroenke, 2010) was utilized in this study as a screening instrument to assess the common co-occurrence of somatization, anxiety, and depression (known as the SAD triad as it measures somatic, anxiety, and depressive symptoms). The instrument combines three measures: the PHQ–9 discussed above, the GAD–7, and the PHQ–15. This questionnaire also screens for panic symptoms. Kroenke and colleagues (2010) noted that the PHQ–9, GAD–7, and PHQ–15 are all well-validated measures for detecting and monitoring depression, anxiety, and somatization. The PHQ–SADS also

includes a panic module with five items, scored as follows: A positive response to the first panic question has a sensitivity and specificity of 93% and 78%, respectively (Kroenke et al., 2010). (See Appendix E for a copy of this instrument.)

The PHQ-9 was discussed above and was used at two distinct occasions during this study. The first time it was used was as a screening tool during recruitment, and each potential group participant was screened for depressive symptomatology to see if the individual met inclusion criteria. The second time it was used was as an assessment tool during pre-, mid-, and posttest, and each group participant was assessed for depressive symptomatology. The GAD-7 and PHQ-15 are described below.

Generalized Anxiety Disorder-7 (GAD-7). The Generalized Anxiety Disorder–7 (GAD–7; Spitzer, Kroenke, Williams & Löwe, 2006) was utilized in this study as a standard screening measure for generalized anxiety disorder (GAD). The GAD–7 is a self-report measure with seven items that was developed initially to diagnose GAD. This measure uses a response set similar to the PHQ–9 depression scale. The individual is asked the extent to which he or she has been bothered by anxiety symptoms over the past 2 weeks. The individual responds to each of the seven items as follows: 0 (*not at all sure*), 1 (*several days*), 2 (*over half the days*), and 3 (*nearly every day*). The scores from the GAD–7 could range from 0 to 27, with levels of anxiety symptoms quantified at cutpoints of 5 (*mild anxiety*), 10 (*moderate anxiety),* and 15 (*severe anxiety).* The researchers found that at a cutpoint of ≥10, both sensitivity and specificity exceeded 0.80 (Kroenke et al., 2006).

Having been validated with 2,740 primary care patients, the GAD–7 has been proven to have good sensitivity and specificity as a screening instrument for panic, social

anxiety, and PTSD (Kroenke et al., 2010). One of the GAD–7's strengths, as with the PHQ–9, is that it performs similarly regardless of the way it is administered (i.e., self-administered or administered by an interviewer in person or over the phone) and across sex, age, and racial/ethnic groups (Kroenke et al., 2010). Notwithstanding, one of the weaknesses of the GAD–7 is that it only screens for anxiety symptoms over the past 2 weeks, whereas the *DSM-IV* diagnostic criteria for GAD specifies at least a 6-month duration of symptoms (Kroenke et al., 2010). (See Appendix E for a copy of this instrument.)

The Patient Health Questionnaire–15 (PHQ–15). The Patient Health Questionnaire–15 was used in this study as a part of the PHQ–SADS (discussed above). The PHQ–15 is a self-report questionnaire that assesses for somatic symptoms severity. The measure comprises 15 symptoms that represent more than 90% of somatic symptoms seen in primary care (Kroenke, Spitzer, Williams, & Löwe, 2010). Of the 15 symptoms, clients are asked to rate how much they have been bothered by each symptom during the past month on a scale of 0 (*not at all*) to 2 (*bothered a lot*). Scores from the PHQ–15 can range from 0 to 30, with cutpoints of 5 (*mild somatic symptom severity*), 10 (*moderate somatic symptom severity*), and 15 (*severe somatic symptom severity*). Kroenke and colleagues (2010) asserted that the PHQ–15 is equal or superior to other measures that assess for somatic symptoms and screen for somatoform disorders. (See Appendix E for a copy of this instrument.)

Alcohol Use Disorders Identification Test (AUDIT–C). The Alcohol Use Disorders Identification Test (AUDIT–C) was chosen for this study to measure active alcohol use disorders or hazardous drinking. The AUDIT–C includes three questions that

screen for individuals who have active alcohol use disorders or are hazardous drinkers. The respondent has five answer choices (a-e), indicating extent of alcohol use. The test is scored on a scale of 0-12: a = *0 points*, b = *1 point*, c = *2 points*, d = *3 points*, e = *4 points*. For men, a score of 4 or above indicates an active alcohol use disorder or hazardous drinking, and for women, a score of 3 or above indicates an active alcohol use disorder or hazardous drinking. In a study evaluating the psychometric properties of the AUDIT–C among college student, Barry and colleagues (2015) found that reliability measures for the instrument were satisfactory (0.76), above the 0.70 criteria. (See Appendix F for a copy of this instrument.)

Drug Abuse Screening Test (DAST–10). The Drug Abuse Screening Test (DAST–10; Skinner, 1982) was utilized in this study to measure drug use. The DAST–10 is a 10-item instrument that assesses drug use over the past 12 months. Similar to the AUDIT–C, it is scored on a scale of 0-10: 1 point is added for every "yes" answer, with the exception of Question #3, for which a "no" answer receives 1 point. These points are then scored as follows: 0 = *no problem with drug use*, 1-2 = *a low level of drug use that should be monitored and reassessed at a later date*; 3-5 = *moderate level use that warrants further investigation*; 6-8 = *substantial use that warrants intensive assessment*; and 9-10 = *severe level use that also warrants intensive assessment*. Yudko, Lozhkina, and Fouts (2007) found that DAST–10 yielded satisfactory measures of reliability (0.86 and 0.94), above the 0.70 criteria. (See Appendix G for a copy of this instrument.)

Group Satisfaction Scale (GSS). The Group Satisfaction Scale (GSS; Marshall, Serran, & Cameron, 2010) was utilized for this study to measure participants' satisfaction with each weekly session, as well as with the intervention as a whole. The GSS asks

participants to report on how satisfied they are with the treatment they received within the context of the group (e.g., "I was able to participate and express myself"; "the facilitator understood me and my needs"). Although the GSS has not yet been empirically validated, it is nonetheless a useful guide to identify issues and indicate ways in which a treatment group could be improved (Marshall et al., 2010). For this dissertation study, the GSS was utilized after each of the five weekly group sessions, and minor modifications were made to the measure to align with each weekly session. Additionally, the GSS was utilized after the intervention had been completed, and it was distributed to the group at the conclusion of the booster session. (See Appendix H for a copy of this scale.)

Summary of the measures. The PHQ–SADS, the AUDIT–C, the DAST–10, and the THQ were all used to assess for depressive symptomatology, hazardous drinking, drug use, and traumatic experiences, respectively. These measures were chosen for this study because research has shown that, as a result of socioeconomic marginalization, transgender individuals experience higher rates of HIV infection, drug and alcohol use, and suicide attempts than the general population (Grant et al., 2011). Research has also shown that mental health issues most commonly found amongst transgender individuals are depression, anxiety, PTSD, suicidal ideation, substance abuse (NAMI, 2017), and gender dysphoria (American Psychiatric Association & *DSM-5* Task Force, 2013; Fredriksen-Goldsen et al., 2014).

Procedures

Recruitment. From October 2019 to February 2020, 23 adult participants were recruited to participate in the current study. The researcher created a research study timeline (see Appendix I). The researcher sought assistance from the staff of SFCHC and

Trans: Thrive, asking them to refer their clients who met the criteria for the study. To streamline the recruitment process, the researcher prepared a document for the professional staff at each organization that included recruitment procedures as well as information regarding the nature of the study (see Appendix J). The researcher also created a recruitment flyer (see Appendix K) that contained information regarding basic inclusion criteria and compensation for participation.

The professional staff at each organization, as well as individuals who were participating or had participated in a treatment group, were asked to give the researcher the contact information of those individuals who indicated interest in the research study. For those who heard about the study through the recruitment flyer, they were asked to contact the researcher directly. The researcher then set up a screening interview to meet with those who had expressed interest in participating in the study.

During the screening interview meeting, the researcher administered the PHQ–9 and the THQ to screen for depression and history of trauma. Immediately following the completion of the PHQ–9, the researcher scored the measure so that she could inform the individual whether she qualified to participate in the study. At this same screening interview meeting, the researcher informed the individual about the nature and benefits of the study, as well as the compensation they would receive for participation. Those who met the criteria were then asked to sign the consent form (see Appendix L). All materials, including the PHQ–9, the THQ, and the signed consents forms, were secured in a locked file cabinet that was only accessible to the researcher. The researcher also obtained permission to audiotape the sessions (see Appendix M).

The recruitment process yielded 23 transgender adults, who were screened; 21 of them completed informed consent; and a total of 14 transgender individuals engaged in the intervention, which made possible the formation of three treatment groups.

The COVID-19 pandemic and shelter-in-place order. In March 2020 due to the COVID-19 pandemic, city residents were ordered to shelter-in-place. At this time, SFCHC informed the researcher that, for an undetermined amount of time, they would not be able to offer in-person services to its clients, which included the participants of the study. As a result, the researcher, in consultation with the dissertation committee, adapted the intervention protocol from conducting in person sessions to conducting individual therapy sessions over the phone. With this exception due to the COVID-19 pandemic, all of the other instructions laid out in the transaffirmative CBT manual were followed. According to a systematic review and meta-analysis study regarding electronically delivered CBT (eCBT), findings indicated that eCBT was more effective than face-to-face CBT at reducing depressive symptom severity (Luo et al., 2020).

Treatment groups. Three treatment groups were formed. Between November 2019 to April 2020, these groups met weekly for 5 weeks and then had one booster session 1 month after the last group session. Group 1 completed pretest at Session 1 and posttest at Booster session. Groups 2 and 3 completed measures at three time points: T1 at Session 1; T2 at Session 5; and T3 at Booster session.

Group 1 took place from November 12th, 2019, to January 14th, 2020. Of the five participants in Group 1, one did not return after the first session, and three completed the pretest and posttest measures. However, two participants did not complete the PHQ–9 section of the PHQ–SADS. The midtest was not administered to Group 1. As this group

was completed before the outbreak of the COVID-19 pandemic, all of the sessions were conducted in person.

There were 3 participants in Group 2, which took place from January 28th, 2020, to March 24th, 2020. It was consistent attendance until the COVID-19 pandemic. All three participants completed the PHQ–9 section of the PHQ–SADS during pretest and midtest (Session 5), which took place on February 25th, 2020; due to the shelter-in-place order in San Francisco on March 16th 2020, the booster session took place on March 24th, 2020, with one participant remotely. Individual therapy was conducted over the phone and the session lasted between 2.0 to 2.5 hours. For Group 2, only one participant completed all three: the pre-, mid-, and posttest, including the PHQ–9 section of the PHQ–SADS for all three test points. Notably, one of the participants did not have a phone, and therefore, was not able to be reached to make an appointment for the booster session; the other did not respond to the researcher's text messages and phone calls.

Group 3 started out with 6 participants, which took place from February 19th, 2020, to April 15th, 2020. Two dropped out after Session 1 and completed the pretest measures. It was consistent participation until the COVID-19 pandemic disrupted attendance. Due to the shelter-in-place order, Session 5 and the final booster session were conducted remotely. Session 5 was attended by 2 participants; each participant had appointments by phone and individual therapy sessions, which lasted between 2.0 to 2.5 hours. The same 2 participants attended the booster session by phone and individual therapy session, which lasted between 2.0 to 2.5 hours. Therefore, only two individuals completed the intervention for Group 3, and they completed all three: the pre-, mid-, and posttest, including the PHQ–9 section of the PHQ–SADS for all three test points.

Notably, one participant did not have a phone, and another participant did not respond to the researcher's text messages and phone calls.

The time points. According to the IRB protocol, the researcher set out to examine the effectiveness of a transaffirmative CBT group-based intervention at pretest and posttest to measure the participants' depressive symptomatology. For this reason, the Group 1 had two time points, pre-intervention and post-intervention. In this case, the PHQ-SADS, DAST-10, and AUDIT-C were administered at the start of the intervention (pretest) and at the booster session (posttest). However, after Group 1 was completed, clarification was made regarding the intervention protocol, and the researcher adapted the updated protocol and thus set out to examine the effectiveness of the intervention at pre-, mid-, and posttest. Subsequently, for Groups 2 and 3, the PHQ-SADS, DAST-10, and AUDIT-C were administered at three time points: at the start of the intervention (pretest), at the end of the intervention (midtest) and at the booster session (posttest). The intervention protocol is described in the following section.

Storage of data and confidentiality. After each weekly treatment session, individual group session outcome data (the GSS) were collected from each participant, which were then sealed and stored in a secure cabinet until the intervention had been completed. To de-identify participants' information on the assessments, the GSS, and the demographic questionnaire, the researcher requested that each participant create a unique code to be used on all of the forms.

Data collection and analysis. At the conclusion of the booster session, the researcher re-administered the PHQ–SADS, AUDIT–C, and DAST–10, and the GSS was also distributed to group participants to evaluate the intervention as a whole. The study

was based on participant outcome, and data from the student participants were collected and examined as a whole at the conclusion of the entire intervention (after the three treatment groups had been completed). The researcher then entered the study's research data into an SPSS statistical program. Statisticians were hired to assist the researcher with the data analysis. For statistical analysis, the researcher ran one-way repeated measure analysis of variance (ANOVA; Field, 2016) as well as paired samples *t*-test (Laerd Statistics, 2018).

Intervention

The intervention was a group therapy, based on a CBT format that was modified for the transgender population (TA-CBT; Austin & Craig, 2015). The group met weekly over a 5-week period, followed by one booster session 1 month after the end of the last session. The booster session reviewed the improvements or sudden gains group participants had made while undergoing the CBT intervention. During the booster session, group participants strategized with each other on how to maintain the gains they had made, and the researcher discussed with them strategies for relapse prevention (Ross et al., 2008). All intervention treatment groups were facilitated by the researcher and supervised by a licensed clinical social worker at SFCHC. The researcher created a timeline of intervention dates (see Appendix N).

The researcher also used a manual adapted from the CBT model to work with this specific population (see Appendix A). This manual was based on the TA-CBT curriculum summary (Austin & Craig, 2015). Treatment consisted of both CBT techniques for treating depression and psychoeducation, and in each session, an educational component of the CBT model was reviewed.

TA-CBT was designed to be flexibly implemented across a variety of settings and modalities (including both individuals and groups; Austin, 2017). Thus, the time for each group varies, but 50–90 minutes is the general range (A. Austin, personal communication, October 6, 2017). For this study, Sessions 1-5 were each 2 hours in length. Each session was divided into two parts. The first part, which was 90 minutes, focused on the group therapy intervention. In the second part, which was 30 minutes, participants were provided with a meal and asked to complete the GSS form. The booster session was 2.5 hours in length, with the first 90 minutes being focused on the intervention. During the last 60 minutes of the booster session, participants were provided with a meal and asked to complete the PHQ–SADS, AUDIT–C, DAST–10, as well as the end of treatment GSS form.

During each intervention session, participants were directed to complete exercises related to the week's treatment content, and at the end of each session, they were assigned homework to be completed before the next group session. In these in-group exercises and homework assignments, the group members were asked to reflect upon their own lived experiences. Homework from the previous week was reviewed in the subsequent session, during which time the group members were asked to share their experiences, and they were encouraged to offer feedback to other group members.

Each session also included process-oriented techniques, including a check-in and check-out, which allowed the group members to share their experiences from the past week. This also allowed them to identify and discuss any challenges they may have encountered interpersonally over the course of the week, as well as issues that may have arisen for them while working on the homework assignment. At this time, the group

members had the opportunity to articulate how they were feeling in the here-and-now, as well as their reactions to the group process, content, and/or other group members.

Over the course of the 5-week intervention, the group members generated a list of negative attributes that had been foisted upon them because of their transgender identity. As these negative labels made their way onto this list, the researcher encouraged the group members to discuss these negative messages, while also making them aware of how these messages can become internalized and thereby impact how they feel and think about themselves. The facilitator also pointed out how these messages can reinforce depressive symptoms. The specific content and format of the six sessions are described below.

Session 1. In the first session, the researcher reviewed group rules and confidentiality with the participants. The participants were then introduced to the CBT model and minority stress. They learned how thoughts, feelings, reactions, and behaviors all interact within a discrete situation, resulting in the creation and perpetuation of their depressive symptoms. The participants completed the GSS at the end of the session.

Session 2. In the second session, participants learned how various risk factors (e.g., transphobia, social isolation, and family rejection) may impact stress and may lead to depressive symptoms. Participants learned how they are impacted by minority stress and antitransgender and transphobic attitudes and behaviors. Participants also learned about core beliefs, cognitive restructuring, and how to recognize cognitive distortions. The participants completed the GSS at the end of the session.

Session 3. In the third session, participants continued to gain understanding on how thoughts affect feelings, and they learned how to use their thoughts to influence their

feelings in healthier, more adaptive ways. The participants completed the GSS at the end of the session.

Session 4. In the fourth session, participants learned how they can nurture and build hope by overcoming counterproductive thoughts and negative feelings. The participants completed the GSS at the end of the session.

Session 5. In the fifth session, participants were asked to share their story of transitioning (e.g., coming-out experiences) and their experience of internalized transphobia. The participants completed the GSS at the end of the session. For the second and third treatment groups, the participants also completed the PHQ–SADS, AUDIT–C, and DAST–10.

Booster session. The booster session took place 1 month after the conclusion of the five-session group. During this session, the group members were asked to review the improvements or sudden gains they had made while participating in the intervention. In addition, they strategized with each other about how to maintain these gains, and the researcher discussed strategies for relapse prevention (Ross et al., 2008). During this session, participants also learned how to develop social relationships and safe, supportive, and identity-affirming social networks. The participants completed the PHQ–SADS, AUDIT–C and DAST–10.

Research Design

The research design implemented a pre-post, group therapy intervention effectiveness study, which was conducted at the San Francisco Community Health Center (SFCHC) beginning mid-November 2019, and ending mid-April 2020. In mid-March, due to the COVID-19 pandemic and the shelter-in-place order in San Francisco, the

remaining therapy sessions were modified and conducted over the phone with individual therapy sessions. For the intervention, three separate groups of three to six transgender individuals were formed, and each group was conducted over a 5-week period: Group 1 met from November 12th to December 10th, 2019, with the booster session taking place on January 14th, 2020. Group 2 met from January 28th to February 25th, 2020, with the booster session taking place on March 24th, 2020. Group 3 met February 19th to March 18th, 2020, with the booster session taking place on April 15th, 2020. The group sessions were 2 hours in length, and the booster session that was held 1 month after the final intervention for each group was 2.5 hours in length.

For statistical analysis, a one-way within subjects (or repeated measures) ANOVA (ANOVA; Field, 2016) was conducted to compare the effect of time on depressive symptoms in pretest, midtest, and posttest conditions. Another one-way with subjects (or repeated measures) ANOVA (ANOVA; Field, 2016) was conducted to compare the effect of time on depressive symptoms in pretest and midtest conditions. The study used time as the independent variable, which was indicated by either two or three assessment time points in the study (pre-, mid-, and posttreatment). The quantitative data (e.g., the PHQ-9 section of the PHQ–SADS scores) assessed change in depressive symptomatology across the two and three time points. The ANOVA (ANOVA; Field, 2016) statistical analysis did not run properly, and it was determined that it was because of the small sample size and low statistical power. Because of this reason, the researcher decided to conduct paired samples t-tests (Laerd Statistics, 2018). A paired samples t-test (Laerd Statistics, 2018) was conducted to compare the mean scores of depressive symptoms in pretest and posttest, and another paired samples t-test (Laerd Statistics,

2018) was conducted to compare the mean scores of depressive symptoms in pretest and midtest. The data were analyzed by the researcher. The researcher was a doctoral clinical psychology student who identified as cis-female, an ally, and had previously trained at SFCHC's mental health department with a focus on providing individual therapy to transgender individuals.

Feasibility of Dissertation Study

The researcher assumed financial responsibility to incentivize participation in the study (maximum total cost estimated to be $2,400). For their participation in the study, participants received a total of $100.00 in cash for completing pre-, mid-, and posttest measures, as well as the GSS satisfaction surveys. The $100.00 incentive was distributed as follows: The participants were given $15.00 at the conclusion of each weekly session and $25.00 at the conclusion of the booster session. Meals were also provided at all sessions.

Data Analysis Plan

Data analysis comprises one continuous outcome variable and one categorical predictor variable with more than two categories (Field, 2012). For this study, the continuous outcome variable was the depressive symptomatology, and the categorical predictor variable was time. Fourteen transgender individuals with depressive symptomatology engaged in this intervention.

For statistical analysis, a one-way within subjects (or repeated measures) ANOVA (ANOVA; Field, 2016) was conducted to compare the effect of time on depressive symptoms in pretest, midtest, and posttest conditions. Another one-way with subjects (or repeated measures) ANOVA (ANOVA; Field, 2016) was conducted to

compare the effect of time on depressive symptoms in pretest and midtest conditions. Time was the independent variable, which was indicated by either two or three assessment time points in the study (pre-, mid-, and posttreatment). The quantitative data (e.g., the PHQ-9 section of the PHQ–SADS scores) assessed change in depressive symptomatology across the two and three time points. The ANOVA (ANOVA; Field, 2016) statistical analysis did not run properly, and it was determined that it was because of the small sample size and low statistical power. Because of this reason, the researcher decided to conduct paired samples t-tests (Laerd Statistics, 2018). A paired samples t-test (Laerd Statistics, 2018) was conducted to compare the mean scores of depressive symptoms in pretest and posttest, and another paired samples t-test (Laerd Statistics, 2018) was conducted to compare the mean scores of depressive symptoms in pretest and midtest. The data were analyzed by the researcher.

In addition to the PHQ-9 section of the PHQ–SADS, which assessed for depressive symptomatology, the researcher administered the AUDIT–C to assess for alcohol use, the DAST–10 to assess for drug use, and the THQ to determine whether participants had experienced potentially traumatic events, which were included in the analysis. The researcher used the GSS at each session to ascertain each participant's satisfaction with the session, and the GSS was again given at the booster session to ascertain the participants' satisfaction with the entire intervention. The GSS tests were sealed and filed in a secure cabinet until the end of treatment. At the conclusion of the intervention for each group, the data were collected and analyzed using Statistical Software (SPSS 22).

Within-subject ANOVAs were chosen as the main method for data analysis for several reasons. First, this method of data analysis uses the same rationale as paired *t*-tests. Second, it is appropriate for repeated measures (i.e., pretest-posttest designs) and within-subjects experimental designs. Third, within-subjects designs have greater power to detect significance, as each participant serves as his or her own control, and as such, any variance due specifically to individual differences is eliminated. Fourth, the error term used in within-subjects ANOVAs is more precise because individual differences have been removed. Fifth, the separate estimation of variance due to individual differences is explicit in the sum of squares for subject (SSS), which is computed by finding the mean score for each case. SSS represents individual variation, whereas SST represents the average of all scores for the sample (Newsom, 2013).

To analyze the results of the PHQ-9 section of the PHQ-SADS, a paired samples *t*-test was run through SPSS. The paired samples *t*-test compared the measurement taken at two different times from the same individual on the same continuous, dependent variable (Laerd Statistics, 2018). In this study, the measurement was taken at pretest and posttest, and at pretest and midtest, with an intervention administered between the two points (SPSS Tutorials, 2021). As such, the integrity was maintained of the within-subjects ANOVA as the main method for data analysis, as this method used the same rationale as paired samples *t*-tests.

Before moving forward with the paired samples t-test statistical analysis, the researcher had to take into account four assumptions to be true in order for the paired samples *t*-test to provide a valid result (Laerd Statistics, 2018)..

Assumption 1: The dependent variable, depressive symptomatology, was measured on a continuous scale.

Assumption 2: The independent variable, time, consisted of two related groups, where each participant was present in both groups. The same participant in each group was measured on two occasions (e.g., pretest and posttest) on the same dependent variable, depressive symptomatology.

Assumption 3: There were no significant outliers in the differences between the two related groups.

Assumption 4: The distribution of the differences in the dependent variable, depressive symptomatology, between the two related groups should be approximately normally distributed.

This study addressed the following research question and corresponding analysis plan based on the following steps: Is a transaffirmative, group-based, CBT intervention effective in treating symptoms of depression among transgender individuals?

To measure baseline variables (pretest assessment), the researcher assessed each participant primarily for depression and also assessed for anxiety and somatic complaints using the PHQ–SADS. Additionally, the researcher screened for trauma using the THQ, and assessed for drug use using the DAST–10 and for alcohol use using the AUDIT–C. These measures were administered prior to the start of the 5-week intervention.

- During the midtest assessment, the researcher again assessed each participant primarily for depression, as well as for anxiety and somatic complaints using the PHQ–SADS. Additionally, the researcher assessed for drug use using the

DAST–10 and for alcohol use using the AUDIT–C. The midtest assessment was administered during the second and third treatment groups.

- For outcome measures (posttest assessment), the researcher assessed each participant a third and final time using the PHQ–SADS. The measure was administered after the conclusion of the booster session. The DAST–10 and the AUDIT–C were also re-administered at this time.
- A within-participants analysis of variance (ANOVA) was conducted for each treatment group using time as the independent variable and depressive symptomatology as the dependent variable. A paired samples t-test was also conducted.

CHAPTER IV

Results

Demographics

Descriptive data for the study sample is presented in Table 1 below. Fourteen transgender individuals with depressive symptomatology engaged in the intervention. These 14 participants represented the total purposive sample in the transaffirmative CBT group intervention. The participants were between 30 and 67 years of age (mean = 47.93 years, *SD* = 11.344). With respect to the gender diverse study sample, 12 (85.7%) identified as female; one (7.1%) identified as nonbinary, third gender; and one (7.1%) preferred not to say. Recruitment stated that group participants needed to identify as female even though that identity was not endorsed throughout the current study. The two individuals who did not identify as female still participated in the study, as both of them identified as transgender, were above 18 years of age, and reported depressive symptoms. With respect to ethnicity or race, seven (50%) identified as White; three (21.4%) identified as being of Asian origin; two (14.3%) identified as being of Hispanic, Latino, or Spanish origin; one (7.1%) identified as Black or being of African American origin; and one (7.1%) identified as American Indian or Alaska Native. In regards to HIV status, four of the participants (28.6%) were HIV positive and four (28.6%) were HIV negative. Six (42.9%) of the participants declined to respond to this question. (See Table 1 below for more details).

Trauma

Twelve transgender individuals completed the Trauma Health Questionnaire (THQ) during the initial screening. The THQ helps to identify traumatic life experiences

and to analyze the relationship between traumatic life experiences and medical conditions, psychological distress, mental illness, and substance use disorders (Hooper et al., 2011). Even though transgender and gender nonconforming individuals report traumatic symptoms that align with a PTSD diagnosis, according to the Diagnostic and Statistical Manual of Mental Disorders, they are exposed to events, such as prejudice, that do not meet the criteria for trauma (Austin, Craig, & Alessi, 2017).

Ten transgender individuals (71.4%) have had someone attempt to rob them or has actually robbed them (i.e., stolen personal belongings). Nine transgender individuals (64.3%) have had someone try to take something directly from them by using force or threat of force, such as a stick-up or mugging. Eight transgender individuals (57.1%) have received news of a serious injury, life threatening illness, or unexpected death of someone close to them. Eight transgender individuals (57.1%) have had someone make them have intercourse or oral or anal sex against their will. Seven transgender individuals (50.0%) have been in any other situation in which they feared they might be killed or seriously injured. Seven transgender individuals (50.0%) have seen someone seriously injured or killed. Six transgender individuals (42.9%) have had a serious accident at work, in a car, or somewhere else. Six transgender individuals (42.9%) have had a serious or life-threatening illness. Six transgender individuals (42.9%) have had someone touch private parts of their body, or made them touch theirs, under force or threat. Six transgender individuals (42.9%) have had someone in their family beaten, spanked, or pushed them hard enough to cause injury.

Table 1

Demographic Data

	Frequency	Percent
1. Total Sample Size	14	
2. Gender of Participants		
Female	12	85.7
Nonbinary, third gender	1	7.1
Prefer not to say	1	7.1
3. Identify as Transgender		
Yes	14	100.0
4. Origin of Ethnicity or Race		
White	7	50.0
Black of African American	1	7.1
Hispanic, Latino, or Spanish Origin	2	14.3
American Indian or Alaska Native	1	7.1
Asian	3	21.4
5. Employment Status		
Out of work and looking for work	1	7.1
Out of work but not currently looking for work	4	28.6
Unable to work	8	57.1
Retired	1	7.1
6. Relationship Status		
Single, never married	1	7.1
Married or domestic partnership	2	14.3
Divorced	2	14.3
In a relationship	1	7.1
In a polygamous relationship	1	7.1
Total	13	92.9
Missing	1	7.1
7. HIV Status		
HIV positive	4	28.6
HIV negative	4	28.6
Total	8	57.1
Missing	6	42.9

Research Question 1/Hypothesis

RQ1. Is a transaffirmative, group-based, CBT intervention effective in treating symptoms of depression among transgender individuals?

$H1_0$ There will not be a statistically significant difference between pretest and posttest of depressive symptomatology after the transaffirmative CBT intervention.

$H1_1$ There will be a statistically significant difference between pretest and posttest of depressive symptomatology after the transaffirmative CBT intervention.

Descriptive data for depressive symptomatology is presented in Table 2 above.

Table 2

Descriptive Statistics for Dependent Variables: Depressive Symptomatology

Time Points	Group	Mean	*SD*	*N*
T1	1	10.6000	7.36885	5
	2	14.0000	2.64575	3
	3	12.6667	3.50238	6
T2	1			
	2	13.3333	6.02771	3
	3	8.0000	5.656585	2
T3	1	11.3333	9.07377	3
	2			
	3	8.0000	8.48528	2

*Mean score: moderate depression

Normality assumptions were met (SW (6) =0.815, p>0.05) and a paired samples t-test was conducted, which compares the mean scores of depressive symptoms in T1 and T3. The dependent variable is depressive symptomatology. Table 3 depicts the mean score of depressive symptoms at T1 is 12.5000 which indicates moderate depression and the mean score of depressive symptoms at T3 is 10.0000 which also indicates moderate

depression. The value of the Shapiro-Wilk test is greater than 0.05; the data is normal. (See Table 3.)

Table 3

Paired Samples Statistics: Depressive Symptomatology Between T1 and T3

Time Points	*N*	Mean	*SD*
T1	6	12.5000*	6.53452
T3	6	10.0000	7.07107

*Mean score: moderate depression

Due to the means of T1 and T3 (depressive symptoms) and the direction of the t-value t(5)=3.273, p=.022 in Table 4 below, we can conclude that there was a significant difference in depressive symptoms following the CBT intervention because p value is less than 0.05, as depicted in 0.022. However, there was no change in the severity of depression which remained at moderate severity.

Table 4

Paired Samples Test: Paired Differences Depressive Symptomology: Between T1 and T3

95% CI of Lower Difference	95% CI of Upper Difference	*T*	Sig. (2-tailed)
.53669	4.46331	3.273	0.022

*CI: Confidence Interval

A paired-samples t-test was conducted to compare depressive symptoms in pretest (T1) and posttest/booster (T3). There was a significant difference in the scores for T1 (M=12.5, SD=6.53) and T3 (M=10.0, SD=7.07); t(5)=3.273, p=.022. These results suggest that time had an effect on depressive symptoms from pretest to posttest after the CBT intervention. However, the severity of depression remained moderate from T1 to T3.

In looking at the findings of the paired samples t-tests, which compared the means depressive scores at T1 and T3 and the means depressive scores at T1 and T2, in which all means depressive scores fell into the moderate depression severity range, was there something notable about what moderate depression meant for T1, in its relation to T3 and T2? If there was, then it may have had to do with the number of participants during each analysis, who participated and the severity of their depressive symptoms, and when the PHQ-9 was measured, either at postintervention or at booster session in the T1 and T3 analysis and in the T1 vs T2 analysis.

Table 5 depicts a significant difference between the mean score of depressive symptoms at T1 is 13.4000 which indicates moderate depression and the mean score of depressive symptoms at T2 is 11.2000 which also indicates moderate depression.

Table 5

Paired Samples Statistics: Depressive Symptomatology Between T1 and T2

Time Points	*N*	Mean	*SD*
T1	5	13.4000*	3.78153
T3	5	11.2000*	5.89067

*Mean score: moderate depression

Due to the means of the two T1 and T2 (depressive symptoms) and the direction of the t-value t(4)=1.438, p=.224 (See Table 6), we can conclude that there was no significant difference in depressive symptoms following the CBT intervention because the p value is greater than 0.05, depicted here as .224. The findings indicated there was no change in the severity of depression which remained at moderate severity.

Table 6

Paired Samples Tests: Paired Differences Depressive Symptomatology Between T1 & T2

95% CI of Lower Difference	95% CI of Upper Difference	*T*	Sig. (2-tailed)
2.04714	6.44714	1.438	0.224

*CI: Confidence Interval

A paired-samples t-test was conducted to compare depressive symptoms in pretest (T1) and midtest/postintervention (T2) (See Table 7 below). There was not a significant difference in the scores for T1 (*M*=13.4, *SD*=3.78) and T2 (*M*=11.2, *SD*=5.89) t(4)=1.438, p=.224. (p>.05). These results suggest that time did not have an effect on depressive symptoms from pretest to midtest after the CBT intervention. The severity of depression remained moderate from T1 to T2.

Table 7

Main Findings: Paired Samples T-*Test: Depressive Symptomatology in T1 and T2*

	A paired-sample *t*-test was conducted to compare depressive symptoms in pretest (T1) and midtest/postintervention (T2). There was not a significant difference in the scores for T1 (M = 13.4, SD = 3.78) and T2 (M = 11.2, SD = 5.89); $t(4) = 1.438$, $p = .224$).
T1 & T2	

> These results suggest there was not a significant difference in depressive symptoms from pretest to midtest after the CBT intervention. The severity of depression remained in the "moderate" range from T1 to T2.

A one-way within subjects (or repeated measures) ANOVA was conducted to compare the effect of time on depressive symptoms in pretest, midtest, and posttest conditions. The findings indicated there was not a significant effect of time on depressive symptoms ($F(2)=.795$, $p=.557$). The analysis could not produce Multivariate test statistics because of insufficient residual degrees of freedom, small sample size, and low statistical power.

Table 8 depicts post hoc findings and summarizes the alcohol and drug use scores, as well as anxiety and somatic complaints among participants in the pretest and the booster period; as well as the pretest and posttest. Looking at the significance column, as the p value was > than 0.05, there were no significant differences in somatic complaints, anxiety, alcohol & drug use, and participant satisfaction for T1 and T3, as well as for T1 and T2.

Table 8

Paired Samples Statistics: Exploratory Analysis

	Mean	*N*	*SD*	Sig. (2-Tailed)
Somatic Complaints T1	6.857	7	3.848	.702
Somatic Complaints T3	6.429	7	5.061	
Somatic Complaints T1	7.000	5	3.391	.577
Somatic Complaints T2	7.800	5	5.404	
Anxiety T1	8.143	7	6.040	.321
Anxiety T3	9.286	7	7.804	
Anxiety T1	11.000	5	5.000	.648
Anxiety T2	10.600	5	6.427	
Alcohol Use T1	1.857	7	2.193	1.000
Alcohol Use T3	1.857	7	2.268	
Alcohol Use T1	3.000	5	4.123	.529
Alcohol Use T2	3.600	5	3.507	
Drug Use T1	1.857	7	2.116	.625
Drug Use T3	1.286	7	2.563	
Drug Use T1	2.000	5	2.550	1.000
Drug Use T2	2.000	5	2.000	
Participant Satisfaction T1	54.430	7	4.928	.169
Participant Satisfaction T3	58.570	7	2.992	
Participant Satisfaction T1	54.780	9	4.324	.481
Participant Satisfaction T2	52.670	9	18.379	

CHAPTER V

Discussion and Conclusion

Discussion

The purpose of the study was to investigate the effectiveness of a transaffirmative cognitive behavioral therapy (CBT) group-based intervention for transgender individuals suffering from depression. Although numerous studies have addressed many of the issues associated with this population, these studies are inadequate to guide professionals, and in particular, mental health professionals, who work with this population in providing effective, more informed treatment. The problem of this study was that a culturally adapted modality, specifically transaffirmative CBT (TA-CBT; Austin & Craig, 2015), has not been widely studied in its impact on depressive symptomatology with mostly transgender women suffering from depression. Clearly, more research is needed in this area.

The results from the paired samples t-test revealed a significant difference in the scores in depression from preintervention to follow-up. Even though there was a difference in the mean depressive symptoms scores, the severity of depression remained in the moderate range; however, the score had lowered in this range. This study provides initial indications that the transaffirmative CBT intervention, designed to reduce depression, may be effective.

Strengths of the Study

Throughout this study, group participants became more aware of the context of the situations they found themselves in. During the weekly group sessions, group participants reported interpersonal challenges and/or contextual issues that heightened

depression (and they understood how it was affecting them), such as conflict with intimate partners, conflict with peers, transdiscrimination, transphobia, and social stigma. They also reported ways in which they handled daily challenges by using CBT skills (e.g., how to use thoughts to influence feelings in healthier, more adaptive ways). The group therapy setting provided a safe and supportive place to voice their thoughts and to look at their thoughts. They were also instrumental in building a safe and supportive structure in the group setting for each other which helped reduce stigma about seeking mental health care.

When the therapy modality changed, individual therapy revealed resiliency. For a transgender individual, resiliency, which is predicated upon protective factors of a person's life, is described as evolving an intuitive definition of self, honoring one's self worth, recognizing oppression, possessing strong social support, cultivating hope, practicing social activism, and being a positive role model (Austin & Craig, 2015; Singh et al., 2011; Singh & McKleroy, 2011). The researcher was able to provide direct interaction with the individuals who attended individual therapy remotely and these one-on-one sessions most likely made it easier for the individuals to become more self-reflective. One individual demonstrated resiliency when she shared that the COVID-19 pandemic, though sudden and uncertain, motivated her to continue her volunteer job to help serve meals to transgender clients. She felt it was important to make sure her peers and colleagues did not go hungry. She also shared she educated her peers and colleagues about wearing masks and gloves, and she pointed out to one of her transgender peers that she is not wearing gloves because she is afraid they may be contaminated with the virus, but that she is wearing gloves to protect them from her.

When the intervention changed therapy modalities from in-person group therapy to remote individual therapy, the researcher was able to notice differences in participation. With in-person, group therapy, trust, safety and group cohesion was established. The researcher noticed that she participated less in group discussions, as they were lively and took on a life of their own, and she was able to establish her role in the group as the facilitator of the CBT curriculum and as an active listener. Social connectedness adds increased comfort with an individual's transgender identity and better behavioral health (Austin, Craig, & Alessi, 2017).

With remote, individual therapy and the onset of the COVID-19 pandemic, the one-on-one sessions provided a safe place for the participants to discuss personal experiences and learning, and the participants were also given individual attention.

Based on the data obtained, it is clear that additional studies are warranted to continue to test the efficacy of this treatment modality with different groups, as well as to provide and test the efficacy of intervention for in-person, telehealth, or a combination of the two treatment modalities. However, if the results of this study hold, this treatment could make a significant positive impact on the individuals who participate in the treatment and the communities in which they live.

Limitations

This study has a number of significant limitations. First, the sample size was too small to statistically analyze the differences in cohort effects. Although 23 participants were initially recruited and screened for the study, eight chose not to participate or did not show up for Session 1, and one did not meet inclusion criteria. Of the 14 participants

who engaged in the intervention, two of them attended the first session but did not show up for the second session.

Second, the participants were recruited in San Francisco, and therefore, the results are not generalizable because they only represent one geographical area.

Third, although the ages of the participants varied within the treatment groups from 30 to 67 years of age, there were not enough participants in each age group to allow for age generalization.

Another limitation in the study was the methodology in regards to when the data were collected for depressive symptomatology. In the first treatment group, depressive symptomatology was measured at only two points, pretest/preintervention and at the booster session (posttest). In the second and third treatment groups, depressive symptomatology was measured at all three time points: pre-, mid-, and posttest. To account for this discrepancy in methodology in which depressive symptomatology was measured at two or three different time points, the researcher examined the possibility of analyzing cohort effects within all three groups. However, after the intervention was completed, the findings indicated that the statistical power of the sample size was too small to measure cohort effects.

Another limitation in the study occurred due to the COVID-19 pandemic and shelter-in-place order that ensued in March 2020. After this order was given, the therapy modality changed from face-to-face group therapy to telehealth individual therapy The SFCHC informed the researcher that for an undetermined amount of time, they would not be able to offer in-person services to its clients, which included the participants of the study. As a result, the researcher, in consultation with the dissertation committee, adapted

the intervention protocol from facilitating group therapy sessions in person to conducting individual therapy sessions over the phone. This change in therapy modality and how it was delivered changed the dynamics of the group, as well as the group cohesiveness. In essence, the protective factor of social inclusion and building a safe social network dissipated the charge of being and feeling connected. The abrupt changes COVID-19 pandemic brought upon the world affected every human being. With this study's transaffirmative intervention that was set up to reduce depressive symptomatology among transgender individuals, the uncertainties and upheaval that transpired due to the COVID-19 pandemic affected the participants in ways that the researcher could not record. Ultimately, only half of the participants completed the intervention.

Only the first treatment group was not affected by the COVID-19 pandemic, as it concluded before the shelter-in-place order had been implemented. However, the second and third treatment groups were impacted by the COVID-19 pandemic. For the second group, the posttest or booster session took place on March 24th, 2020, and this session was conducted via telehealth. Only one participant in this group completed pre-, mid-, and posttests. The third treatment group was affected by the COVID-19 pandemic as well, as the mid- or postintervention and the posttest or booster session were conducted via telehealth. Two participants from the third group completed all three tests. With the second and third treatment groups, only three participants completed pre-, mid-, and posttest and by different treatment modalities altogether.

In regard to attrition, as the COVID-19 pandemic caused a disruption in therapeutic care, the number of participants who completed the study dropped by 50 % due to most of the participants not having a means of communication. In Group 2, one of

the participants did not have a phone, and therefore, was not able to be reached to make an appointment for the booster session; and the other participant did not respond to the researcher's text messages and phone calls. In Group 3, one participant did not have a phone, and another participant did not respond to the researcher's text messages and phone calls.

Recommendations for Future Research

As noted above, given the lack of generalizability of this study, future researchers may wish to use a larger participant pool that includes a greater diversity of ethnic, cultural, geographical, and age groups. With this more diverse sample, more extensive analysis could be conducted, such as exploring differences between ethnicities, geographical locations, and age groups. Although the participant pool for this study was transgender women, another recommendation and limitation center on gender diversity of sample. Future research should create an intervention that aims to reduce both depression and anxiety. Future research should also include multiple groups (e.g., control) to support claims about the effectiveness of interventions. Lastly, the creation of a transaffirmative CBT hybrid model intervention that incorporates both in-person and telebehavioral health could be utilized when it is difficult to access care.

Conclusion

The goal of this current study was to determine whether a transaffirmative, group-based, CBT intervention would be effective in treating symptoms of depression among transgender individuals. It is this researcher's hope that this study will help mental health professionals and other professionals who work with this population to better understand them and become more culturally sensitive and culturally responsible to the needs of the

transgender and gender nonconforming (TGNC) population. In short, it is this researcher's hope that this study will help these practitioners to adopt a transaffirming approach to treatment, as there is still a need for continued research in this area.

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APPENDICES

APPENDIX A

ADAPTATION OF TA-CBT CURRICULUM

ADAPTATION OF TA-CBT CURRICULUM

An outline for the weekly session instruction is provided in the table below.

Session	Theme	Activities
1	Introduction to CBT model and minority stress	• Group Introductions • Discuss CBT theory and purpose • What causes stress and minority stress
2	Risk factors and their impact on stress and depressive symptomatology Thoughts, feelings, reactions and behaviors interact and can perpetuate depressive symptomatology	• Check in and review • Discuss risk factors and impact on daily life • Distinguish between thoughts and feelings • Explore how thoughts impact feelings and behaviors • Identify core beliefs • Identify feelings of hopelessness and recognize negative self-talk • Identify cognitive distortions
3	Effect of minority stress, antitransgender and transphobic attitudes and behaviors Discuss coming out experiences and internalized transphobia	• Check in and review • Discuss anti-transgender discrimination and identify how it affects thoughts, feelings, and behaviors • Discuss transphobia and identify how it affects thoughts, feelings, and behaviors • Learn how to be assertive • Learn how to cope with and tackle transphobia

4	Use thoughts to change feelings Introduce mindfulness training	• Check in and review • Learn positive thinking and increase feelings of hope • Change negative thoughts to positive thoughts • Challenge negative thinking and internalized transphobia through the ABCD method • Explore mindfulness training • Guided meditation
5	Overcome counterproductive thoughts and negative feelings by building hope	• Check in and review • Distinguish between clear and unclear goals • Identify short-, mid-, and long-term goals • Fostering hope for the future (hope box)
6	Developing social relationships and safe, supportive, and identity-affirming social networks Relapse prevention	• Check in and review • What are the stressors and what coping skills to use to manage them • Maintaining a healthy social network: Attending to thoughts, expectations, feelings, and behaviors within relationships • Identifying a plan for building a supportive network • Review gains

APPENDIX B

DEMOGRAPHIC QUESTIONNAIRE

DEMOGRAPHIC QUESTIONNAIRE

All participants will be asked to complete a demographic survey to identify their (a) age, (b) gender, (c) race/ethnicity, (d) employment status, (e) relationship status, and (f) HIV status.

(a). **Age.**

(b). **Gender**. *What is your gender?*

Female

Male

Non-binary/third gender

Prefer to self-describe

Prefer not to say

Do you identify as transgender?

Yes

No

Prefer not to say

(c). **Ethnicity Origin (or Race).** *Please check all that apply.*

White

Black or African American

Hispanic, Latino, or Spanish origin

American Indian or Alaska Native

Asian

Native Hawaiian or Other Pacific Islander

Other:

(d). **Employment Status.** *Are you currently...?*

Employed for wages

Self-employed

Out of work and looking for work

Out of work but not currently looking for work

A student

Military

Retired

Unable to work

(e). **Relationship Status.**

Single, never married

Married or domestic partnership

Widowed

Divorced

Separated

(f). **HIV Status.**

HIV + Date:_____ AIDS Date:_____

APPENDIX C

PHQ–9

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	_____
	Somewhat difficult	_____
	Very difficult	_____
	Extremely difficult	_____

A2663B 10-04-2005

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg. every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

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APPENDIX D

TRAUMA HISTORY QUESTIONNAIRE (THQ)

TRAUMA HISTORY QUESTIONNAIRE

The following is a series of questions about serious or traumatic life events. These types of events actually occur with some regularity, although we would like to believe they are rare, and they affect how people feel about, react to, and/or think about things subsequently. Knowing about the occurrence of such events, and reactions to them, will help us to develop programs for prevention, education, and other services. The questionnaire is divided into questions covering crime experiences, general disaster and trauma questions, and questions about physical and sexual experiences.

For each event, please indicate (circle) whether it happened and, if it did, the number of times and your approximate age when it happened (give your best guess if you are not sure). Also note the nature of your relationship to the person involved and the specific nature of the event, if appropriate.

Crime-Related Events		Circle one		***If you circled yes, please indicate***	
				Number of times	**Approximate age(s)**
1	Has anyone ever tried to take something directly from you by using force or the threat of force, such as a stick-up or mugging?	No	Yes		
2	Has anyone ever attempted to rob you or actually robbed you (i.e., stolen your personal belongings)?	No	Yes		
3	Has anyone ever attempted to or succeeded in breaking into your home when you were <u>not</u> there?	No	Yes		
4	Has anyone ever attempted to or succeed in breaking into your home while you <u>were</u> there?	No	Yes		
General Disaster and Trauma		Circle one		***If you circled yes, please indicate***	
				Number of times	**Approximate age(s)**
5	Have you ever had a serious accident at work, in a car, or somewhere else? (**<u>If yes</u>**, please specify below) _____	No	Yes		
6	Have you ever experienced a natural disaster such as a tornado, hurricane, flood or major earthquake, etc., where you felt you or your loved ones were in danger of death or injury? (**<u>If yes</u>**, please specify below) _____	No	Yes		

7	Have you ever experienced a "man-made" disaster such as a train crash, building collapse, bank robbery, fire, etc., where you felt you or your loved ones were in danger of death or injury? (**If yes**, please specify below) _____	No	Yes		
8	Have you ever been exposed to dangerous chemicals or radioactivity that might threaten your health?	No	Yes		
9	Have you ever been in any other situation in which you were seriously injured? (**If yes**, please specify below) _____	No	Yes		
10	Have you ever been in any other situation in which you feared you might be killed or seriously injured? (**If yes**, please specify below) _____	No	Yes		
11	Have you ever seen someone seriously injured or killed? (**If yes**, please specify who below) _____	No	Yes		
12	Have you ever seen dead bodies (other than at a funeral) or had to handle dead bodies for any reason? (**If yes**, please specify below) _____	No	Yes		
13	Have you ever had a close friend or family member murdered, or killed by a drunk driver? (**If yes**, please specify relationship [e.g., mother, grandson, etc.] below) _____	No	Yes		
14	Have you ever had a spouse, romantic partner, or child die? (**If yes**, please specify relationship below) _____	No	Yes		
15	Have you ever had a serious or life-threatening illness? (**If yes**, please specify below) _____	No	Yes		

16	Have you ever received news of a serious injury, life-threatening illness, or unexpected death of someone close to you? (**If yes**, please indicate below) _____	No	Yes		
17	Have you ever had to engage in combat while in military service in an official or unofficial war zone? (**If yes**, please indicate where below) _____	No	Yes		
Physical and Sexual Experiences		Circle one		***If you circled yes, please indicate***	
				Repeated?	**Approximate age(s) and frequency**
18	Has anyone ever made you have intercourse or oral or anal sex against your will? (**If yes**, please indicate nature of relationship with person [e.g., stranger, friend, relative, parent, sibling] below) _____	No	Yes		
19	Has anyone ever touched private parts of your body, or made you touch theirs, under force or threat? (**If yes**, please indicate nature of relationship with person [e.g., stranger, friend, relative, parent, sibling] below) _____	No	Yes		
20	Other than incidents mentioned in Questions 18 and 19, have there been any other situations in which another person tried to force you to have an unwanted sexual contact?	No	Yes		
21	Has anyone, including family members or friends, ever attacked you with a gun, knife, or some other weapon?	No	Yes		
22	Has anyone, including family members or friends, ever attacked you without a weapon and seriously injured you?	No	Yes		
23	Has anyone in your family ever beaten, spanked, or pushed you hard enough to cause injury?	No	Yes		

24	Have you experienced any other extraordinarily stressful situation or event that is not covered above? (**If yes**, please specify below) _____	No	Yes		

APPENDIX E

PHQ–SADS

PATIENT HEALTH QUESTIONNAIRE (PHQ-SADS)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability

A. During the last 4 weeks, how much have you been bothered by any of the following problems?		Not bothered (0)	Bothered a little (1)	Bothered a lot (2)
1.	Stomach pain	☐	☐	☐
2.	Back pain	☐	☐	☐
3.	Pain in your arms, legs, or joints (knees, hips, etc.)	☐	☐	☐
4.	Feeling tired or having little energy	☐	☐	☐
5.	Trouble falling or staying asleep, or sleeping too much	☐	☐	☐
6.	Menstrual cramps or other problems with your periods	☐	☐	☐
7.	Pain or problems during sexual intercourse	☐	☐	☐
8.	Headaches	☐	☐	☐
9.	Chest pain	☐	☐	☐
10.	Dizziness	☐	☐	☐
11.	Fainting spells	☐	☐	☐
12.	Feeling your heart pound or race	☐	☐	☐
13.	Shortness of breath	☐	☐	☐
14.	Constipation, loose bowels, or diarrhea	☐	☐	☐
15.	Nausea, gas, or indigestion	☐	☐	☐

PHQ-15 Score ☐ = ____ + ____

B. Over the last 2 weeks, how often have you been bothered by any of the following problems?		Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1.	Feeling nervous anxiety or on edge	☐	☐	☐	☐
2.	Not being able to stop or control worrying	☐	☐	☐	☐
3.	Worrying too much about different things	☐	☐	☐	☐
4.	Trouble relaxing	☐	☐	☐	☐
5.	Being so restless that it is hard to sit still	☐	☐	☐	☐
6.	Becoming easily annoyed or irritable	☐	☐	☐	☐
7.	Feeling afraid as if something awful might happen	☐	☐	☐	☐

GAD-7 Score ☐ = ____ + ____ + ____

C. Questions about anxiety attacks.

	NO	YES
a. In the last 4 weeks, have you had an anxiety attack — suddenly feeling fear or panic? If you checked "NO", go to question E.	☐	☐
b. Has this ever happened before?	☐	☐
c. Do some of these attacks come suddenly out of the blue — that is, in situations where you don't expect to be nervous or uncomfortable?	☐	☐
d. Do these attacks bother you a lot or are you worried about having another attack?	☐	☐
e. During your last bad anxiety attack, did you have symptoms like shortness of breath, sweating, or your heart racing, pounding or skipping?	☐	☐

D. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be beter off dead of or hurting yourself in some way	☐	☐	☐	☐

PHQ-9 Score ☐ = ____ + ____ + ____

E. If you checked off any problems on this questionnaire, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

APPENDIX F

AUDIT–C QUESTIONNAIRE

Name _____ Date of Visit _____

1. How often do you have a drink containing alcohol?

a. Never
b. Monthly or less
c. 2-4 times a month
d. 2-3 times a week
e. 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day?

a. 1 or 2
b. 3 or 4
c. 5 or 6
d. 7 to 9
e. 10 or more

3. How often do you have six or more drinks on one occasion?

a. Never
b. Less than monthly
c. Monthly
d. Weekly
e. Daily or almost daily

APPENDIX G

DAST–10 QUESTIONNAIRE

DAST–10 QUESTIONNAIRE

I'm going to read you a list of questions concerning information about your potential involvement with drugs, excluding alcohol and tobacco, during the past 12 months.

When the words "drug abuse" are used, they mean the use of prescribed or over-the-counter medications/drugs in excess of the directions and any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g., marijuana, hash), solvents, tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions do not include alcohol or tobacco.

If you have difficulty with a statement, then choose the response that is mostly right. You may choose to answer or not answer any of the questions in this section.

These questions refer to the past 12 months.	**No**	**Yes**
1. Have you used drugs other than those required for medical reasons?	0	1
2. Do you abuse more than one drug at a time?	0	1
3. Are you always able to stop using drugs when you want to? (If never use drugs, answer "Yes."	1	0
4. Have you had "blackouts" or "flashbacks" as a result of drug use?	0	1
5. Do you ever feel bad or guilty about your drug use? If never use drugs, choose "No."	0	1
6. Does your spouse (or parents) ever complain about your involvement with drugs?	0	1
7. Have you neglected your family because of your use of drugs?	0	1
8. Have you engaged in illegal activities in order to obtain drugs?	0	1
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	0	1
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	0	1

Skinner, H. A. (1982). The Drug Abuse Screening Test. *Addictive Behavior, 7*(4), 363–371.

APPENDIX H

GROUP SATISFACTION SCALE (GSS)

A GROUP SATISFACTION SCALE

BY

LIAM E.

MARSHALL, Ph.D.

GERIS SERRAN,

Ph.D. (C.PSYCH)

ROCKWOOD PSYCHOLOGICAL SERVICES

&

COLIN CAMERON, MDCM, FRCPC

ROYAL OTTAWA HEALTH CARE GROUP – SECURE TREATMENT UNIT

Address for correspondence:

GSS

c/o ROCKWOOD PSYCHOLOGICAL SERVICES

303 BAGOT STREET, SUITE 304, KINGSTON, ON., CANADA, K7K 5W7

www.rockwoodpsyc.com; Email:

data@rockwoodpsyc.com PHONE: 011 613

530 3606; FAX: 011 613 530 2895

HOW TO DO IT?

- ☐ It is preferable if a different person than the treatment provider(s) asks for participation and collects the completed questionnaires. This is to reduce the tendency of respondents to be either overly critical or overly positive in their responses.

- ☐ When a participant has completed the entire treatment group, ask him to complete a questionnaire on how satisfied they were with the treatment they received. Tell them their responses will be kept anonymous and will help make changes to improve the group.

- ☐ Inform them that their participation is voluntary and that their answers will in no way affect their situation or treatment report. Their responses are, and will remain, completely anonymous and they are not to put their name anywhere on the form. All data will be reported in group format so that it will be impossible to identify any individual who completed a questionnaire.

- ☐ Inform them that completing the measure will give them a chance to give their opinion on the quality and value of the treatment group and therapist(s).

- ☐ If they agree to complete the GSS, give them the form and have them complete it. If they would prefer to complete the questionnaire later in private, please give them the form with an envelope and ask them to give it to you, or another trusted staff member, when completed. If they choose to complete the questionnaire later, you will almost certainly have to follow-up with them to get the completed form.

WHEN TO DO IT?

- ☐ It is recommended that the members be approached to complete the questionnaire as soon as possible after the completion of the group. Therapists should advise the data collector when a member has either completed the group or is to be removed from the group.

- ☐ Because some group members may be resistant and suspicious as to how completing the measure will affect their situation and treatment report, you will need to use your best judgement as to when to ask them to complete the questionnaire. If they seem like they might be receptive, you can ask them as soon as they complete treatment. If they seem particularly agitated or upset to be asked to participate in the survey that day, it may be best to approach them at a later date. Or, it may also be wise to ask someone who has a good relationship

with the offender (e.g., a prison officer on his unit, his parole officer or case manager, nurse, psychiatrist, work supervisor) to ask him to complete and return the measure.

WHO CAN I APPLY THE GSS TO?

- ☐ The GSS was developed for use with incarcerated offenders however the issues in the GSS apply to any form of group treatment.

WHO CAN USE THE GSS?

- The GSS is a license free measure; that is, there is no cost associated with its use. However, please use the reference below to cite the measure in any publications or presentations. You may also modify the measure to suit your particular site's needs. Adding many more items is not, however, recommended.

- Using the GSS does not require any particular educational level (e.g., Bachelor, Masters, Ph.D, MD) in any particular discipline (e.g., Psychology, Psychiatry, Social Work). However, knowledge of data analyses and, in particular, psychometrics enhances the ability to interpret the results of the GSS.

INTERPRETATION

- The GSS has not yet been empirically validated. It is, however, based on an extensive review of the psychological literature on effective group process and research on effective therapist features by Marshall and his colleagues (2001; 2003). At the current moment the GSS is intended as a guide for therapists and organizations in order to inform on issues that could improve treatment groups.

- SUPERVISION: it is suggested to use the mean from a variety of different and similar groups as a guide to giving feedback on satisfaction with therapist and therapeutic process to therapists. That is, therapists and groups can be compared to the overall mean for all groups, and for other groups of the same kind (if there are more than one of the same group run in either the facility or the organization).

- This can also be applied to comparing groups for different issues - such as anger management, sexual offending, cognitive skills, domestic violence - on content and other features of these groups.

SCORING THE GSS

- TOTAL SCORE: sum all of the items (#1-10) except the overall rating of the therapist and the group (Items # 11 & 12).

- SATISFACTION WITH THERAPIST SUBSCALE: sum items # 2,4,6,8 - these items reflect issues related to effective therapists (i.e., being Warm, Empathic, Rewarding, and Directive).

- CONTENT/GROUP PROCESS SUBSCALE: sum items #1, 3, 5, 7, 9, & 10. These items reflect what is known about effective group process (e.g., Group Cohesion, Emotional Expressiveness).

- Through statistical procedures such as factor analyses and scale reliability analyses, the subscale and total scores can be compared to the overall ratings of the therapist (Item # 11) and group (Item # 12).

NOTE: For a nominal fee Rockwood Psychological Services is available to help interpret collected data – email: data@rockwoodpsyc.com

REFERENCE FOR THE SCALE

Marshall, L. E., Serran, G., & Cameron, C. (2010). *The Group Satisfaction Scale.* Unpublished Manuscript available from the first author: liam@rockwoodpsyc.com.

GROUP SATISFACTION SCALE

Group Session "x"

Date:

Group Session #:

Facilitator:

		Completely False	*Mostly False*	*Neither True nor False*	*Mostly True*	*Completely True*
1	The group session was well organized	1	2	3	4	5
2	The facilitator cared about me as a person	1	2	3	4	5
3	The group members worked together to achieve goals	1	2	3	4	5
4	The facilitator noticed and told me when I did something well	1	2	3	4	5
5	I was able to participate and express myself	1	2	3	4	5
6	The facilitator encouraged me to achieve my goals	1	2	3	4	5
7	The focus of the group session was on the right issues	1	2	3	4	5
8	The facilitator understood me and my needs	1	2	3	4	5
9	I learned what I was hoping to learn	1	2	3	4	5
10	The group session/information was easy to understand	1	2	3	4	5
		Poor	*fair*	*Good*	*Very Good*	*Excellent*
11	Overall rating of the facilitator	1	2	3		5
12	Overall rating of the group session	1	2	3		5

Additional Comments (for example, any suggestions you have for how the group session might be improved).
(Please continue on back of page if more room is needed)

GROUP SATISFACTION SCALE

END OF TREATMENT

Date:

Facilitator:

		Completely False	*Mostly False*	*Neither True nor False*	*Mostly True*	*Completely True*
1	The group was well organized	1	2	3	4	5
2	The facilitator cared about me as a person	1	2	3	4	5
3	The group members worked together to achieve goals	1	2	3	4	5
4	The facilitator noticed and told me when I did something well	1	2	3	4	5
5	I was able to participate and express myself in the group	1	2	3	4	5
6	The facilitator encouraged me to achieve my goals	1	2	3	4	5
7	The focus of the group was on the right issues	1	2	3	4	5
8	The facilitator understood me and my needs	1	2	3	4	5
9	I learned what I was hoping to learn	1	2	3	4	5
10	The group/information was easy to understand	1	2	3	4	5
		Poor	*Fair*	*Good*	*Very Good*	*Excellent*
11	Overall rating of the facilitator	1	2	3	4	5
12	Overall rating of the group	1	2	3	4	5

Additional Comments (for example, any suggestions you have for how the group might be improved).
(Please continue on back of page if more room is needed)

APPENDIX I

Research Study Timeline

Research Study Timeline

Defense proposal submitted to dissertation committee	9/20/17
IRB protocol and consent forms submitted for review by USF IRB Board	9/22/17
Dissertation proposal defense meeting with dissertation committee	9/28/17
Dissertation proposal approved by committee chair	10/13/17
Recruitment	10/19 – 02/20

APPENDIX J

Study and Recruitment Information for SFCHC Professional Staff

Joy Riach, M.S., is a graduate student at the University of San Francisco in the Department of Integrated Healthcare and is conducting this study under the advisement of her clinical dissertation chair, David A. Martinez, Ph.D.

PURPOSE OF STUDY:
The purpose of this research study is to investigate an intervention designed for transgender women who are suffering from depression.

DETAILS OF STUDY:
The study is a 5-week group-based therapy intervention that utilizes a Cognitive Behavioral Therapy (CBT) model. The researcher will evaluate the effectiveness of this intervention using pre-and postintervention measures to determine whether the level of depression decreased among group participants.

DURATION AND LOCATION OF THE STUDY:

Sessions 1-5: 2 hours
Booster session: 2 ½ hours

Location: SFCHC

POTENTIAL RISKS AND DISCOMFORTS:
We do not anticipate any risks or discomforts from participating in this research; however, participants may experience emotional discomfort when completing survey questions and measures.

BENEFITS:
Participation in this study may lead to the following benefits:
1. Learn more about factors, such as depression, anxiety, minority stress, social support, individual acceptance, transphobia, social isolation, and gender abuse.
2. Learn more about Cognitive Behavioral Therapy (CBT), and how CBT can be used as an effective coping strategy in daily life.

COMPENSATION/PAYMENT FOR PARTICIPATION:
Participants will receive a total of $100.00 in cash for completing pre-, mid-, and posttest measures, as well as satisfaction surveys for their participation in the study. Participants will be given $15.00 at the conclusion of each weekly session and $25.00 at the conclusion of the booster session. Meals will also be provided at each weekly session as well as at the booster session. Early withdrawal from the study will not result in any compensation.

VOLUNTARY NATURE OF THE STUDY:
Participation is voluntary. Participants may skip any questions or tasks that make them uncomfortable, refuse to participate, or discontinue participation at any time without penalty or loss of benefits. In addition, the researcher has the right to withdraw

participants from participation in the study at any time. Withdrawal from the study will not affect treatment or accessing resources at SFCHC.

QUESTIONS AND CONTACT INFO:
Principal Investigator: Joy Riach at (707) 739-6650 or jlriach@usfca.edu

RECRUITMENT INFORMATION:

- Eligibility Criteria: (a) self-identify as a transgender woman; (b) 18 years old or older; and (c) has mild, moderate, or severe depressive symptoms.
- Study participants will be recruited through organizations serving the LGBTQ community in the San Francisco Bay Area, including the San Francisco Community Health Center (SFCHC), Trans:Thrive and Trans Access. As part of the recruitment process, professional staff at these organizations will refer individuals, who meet the inclusion criteria for participation in the study, to this researcher.
- Study participants will also be recruited via flyer or word-of-mouth.
- When individuals have indicated interest, professional staff at each organization will give them the researcher's contact information.
- When an individual responds to the recruitment flyer, information on the flyer will direct the potential participant to contact the researcher directly.
- The researcher will be responsible for administering the PHQ–9 to all potential participants.
- Only the researcher will score the PHQ–9. Individuals who have mild, moderate or severe depressive symptoms will be contacted directly by the researcher, and the researcher will schedule an individual screening meeting. During this meeting, if the individual meets the inclusion criteria, the researcher will ask the individual to sign a consent form.
- The PHQ–9 data and the signed consent forms will be kept in a locked file cabinet.

APPENDIX K

Recruitment Flyer

PURPOSE OF STUDY:
The purpose of this research study is to investigate an intervention designed for transgender women who are suffering from depression.

ELIGIBILITY:
- Self-identify as a transgender woman
- 18 years or older
- Has mild, moderate or severe depressive symptoms

DETAILS OF STUDY:
The study is a 5-week group-based therapy intervention that utilizes a Cognitive Behavioral Therapy (CBT) model. The researcher will evaluate the effectiveness of this intervention using pre-, mid-, and posttests to determine whether the level of depression decreased among group participants.

DURATION AND LOCATION OF THE STUDY:

Sessions 1-5:	2 hours
Booster session:	2 ½ hours

Location: SFCHC

POTENTIAL RISKS AND DISCOMFORTS:
We do not anticipate any risks or discomforts from participating in this research; however, participants may experience emotional discomfort when completing survey questions and measures.

BENEFITS:
Participation in this study may lead to the following benefits:
1. Learn more about factors, such as depression, anxiety, minority stress, social support, individual acceptance, transphobia, social isolation, and gender abuse.
2. Learn more about Cognitive Behavioral Therapy (CBT), and how CBT can be used as an effective coping strategy in daily life.

COMPENSATION/PAYMENT FOR PARTICIPATION:
Participants will receive a total of $100.00 in cash for completing pre-, mid-, and posttest measures, as well as satisfaction surveys for their participation in the study. Participants will be given $15.00 at the conclusion of each weekly session and $25.00 at the conclusion of the booster session. Meals will also be provided at each weekly session as well as at the booster session. Early withdrawal from the study will not result in any compensation.

VOLUNTARY NATURE OF THE STUDY:
Participation is voluntary. Participants may skip any questions or tasks that make them uncomfortable, refuse to participate, or discontinue participation at any time without penalty or loss of benefits. In addition, the researcher has the right to withdraw participants from participation in the study at any time. Withdrawal from the study will not affect treatment or accessing resources at SFCHC.

QUESTIONS AND CONTACT INFO:
Principal Investigator: Joy Riach at 707-739-6650 or jlriach@usfca.edu


Are you experiencing depressive symptoms?
If so, please contact us about participating in our research study to learn about Cognitive Behavioral Therapy (CBT) and how CBT can be used as an effective coping strategy in daily life.
We are looking for participants who meet the following criteria:
• You self-identify as a transgender woman
• You are between the ages of 18 and 65
• You are experiencing depressive symptoms
Contact Joy Riach at jriach@sfsu.edu
or call (707) 739-6650

APPENDIX L

Consent Form

CONSENT TO PARTICIPATE IN A RESEARCH STUDY:

Below is a description of the research procedures and an explanation of your rights as a research participant. You should read this information carefully. If you agree to participate, you will sign in the space provided to indicate that you have read and understand the information on this consent form. You are entitled to and will receive a copy of this form.

You have been asked to participate in a research study conducted by Joy Ventura Riach, a graduate student in the Department of Clinical Psychology PsyD Program, School of Nursing and Health Professions, at The University of San Francisco. This faculty supervisor for this study is Dr. David A. Martinez, an assistant professor in the Clinical Psychology PsyD Program, School of Nursing and Health Professions, at The University of San Francisco.

WHAT THE STUDY IS ABOUT:

The purpose of this research study is to investigate an intervention designed for transgender women suffering from depression. The intervention itself is a 5-week group-based therapy that utilizes a CBT model. This researcher will evaluate the effectiveness of this intervention using pre- and posttests to determine whether the level of depression of transgender women in the study has decreased. In addition, this study will also assess the feasibility of a pilot intervention using a culturally adapted treatment for adult transgender women with depression.

WHAT WE WILL ASK YOU TO DO:

During this study, the researcher will set out to recruit 18-24 adult participants, who meet the inclusion criteria of having mild, moderate or severe depressive symptoms. Ideally the researcher will recruit 24 participants and will contact each of them to schedule individual screening meetings.

During the screening interview meeting, the researcher will administer the PHQ–9 and also screen for a history of trauma (i.e., Trauma History Questionnaire). The researcher will score the PHQ–9, and individuals who meet the inclusion criteria for depression will be told on the spot or contacted at a later time of their eligibility to participate in the research study. At this same screening interview meeting, the researcher will explain to each eligible participant the nature of the study, the benefits of the study, the

compensation for participation, and then will ask the participant to sign a consent form. Subsequently, the data from the PHQ–9 and the THQ, as well as the signed consent form, will be kept in a locked file cabinet. Before the study begins, each participant will be asked to complete a demographic questionnaire and will also be administered the AUDIT–C, which screens for alcohol use, the DAST–10, which screens for drug use, and the PHQ–SADS scale (Kroenke, Spitzer, Williams, & Löwe, 2010), which tests for depression or anxiety present with somatic complaints. The PHQ–SADS, DAST–10, and AUDIT–C are administered at pretest, midtest, and posttest. Treatment will consist of a combination of psychoeducation and CBT techniques for treating depression; in each session, an educational component of the CBT model will be reviewed. At the conclusion of each weekly session, participants will be asked to complete a Group Satisfaction Survey (GSS) and at the end of the booster session, participants will be asked to complete an end of treatment GSS. The six sessions are described here:

Session 1. In the first session, participants will be introduced to the CBT model and minority stress. They will learn how thoughts, feelings, reactions, and behaviors all interact within a discrete situation, resulting in the creation and perpetuation of their depressive symptoms. The participants will complete a GSS form at the end of the session.

Session 2. In the second session, participants will learn how various risk factors (e.g., transphobia, social isolation, family rejection) impact stress and lead to depressive symptoms. Participants will also learn about how they are impacted by minority stress and anti-transgender and transphobic attitudes and behaviors. The participants will complete a GSS form at the end of the session.

Session 3. In the third session, participants will gain an increased understanding on how thoughts affect feelings, and they will learn how to use their thoughts to influence their feelings in healthier, more adaptive ways. The participants will complete a GSS form at the end of the session.

Session 4. In the fourth session, participants will learn how they can nurture and build hope by overcoming counterproductive thoughts and negative feelings. The participants will complete a GSS form at the end of the session.

Session 5. In the fifth session, participants will be asked to share their story of transitioning (i.e., coming-out experiences) and their experience of internalized transphobia. The participants will complete a GSS form at the end of the session.

Booster session. The booster session will take place 1 month after the conclusion of the 5-session group. During this session, participants will learn how to develop social relationships and safe, supportive, and identity-affirming social networks. Relapse prevention will also be discussed. The participants will complete a PHQ–SADS, AUDIT–C and DAST–10.

During Session 1, the researcher will review group rules and confidentiality with the participants. During each intervention session, participants will be asked to complete exercises related to the week's treatment content, and at the end of each session, they will

be assigned homework to be completed before the next group session. In these in-group exercises and homework assignments, the group members will be asked to reflect upon their own lived experiences. Homework from the previous week will be reviewed in the subsequent session, during which time the group members will be asked to share their experiences, and they will be encouraged to offer feedback to other group members.

Each session will also include process-oriented techniques, such as a "check-in" and "check-out", which will allow the group members to share their experiences from the past week. This also allows them to identify and discuss any challenges they may have encountered over the course of the week, interpersonally, as well as issues that arose for them while working on the homework assignment. At this time, the group members will have the opportunity to articulate how they are feeling in the here-and-now, as well as their reactions to the group process, content, and/or other group members.

Over the course of the 5-week intervention that utilizes a CBT approach, it is anticipated that the group members will be generating a list of negative attributes that have been foisted upon them because of their transgender identity. As these negative labels make their way onto this list, the researcher will encourage the group members to discuss these negative messages, while making them aware of how these messages can become internalized, and thereby impact how they feel and think about themselves. The facilitator will also indicate how these messages may reinforce depressive symptoms. The group members' stories will culminate in the fifth session when the group will be asked to share their coming-out stories or story of transitioning.

The booster session will take place 1 month after the end of the 5-week intervention. During this session, the group will be asked to review the improvements or sudden gains they have made while undergoing the CBT intervention, while strategizing with each other how to maintain these gains, and finally, the researcher will discuss strategies for relapse prevention (Ross et al., 2008).

DURATION AND LOCATION OF THE STUDY:
Your participation in this study will involve participation in a 5-week group therapy intervention, based on a CBT format modified for the transgender population (TA-CBT; Austin & Craig, 2015), which will then be followed 1 month after the end of the last session with one booster session, which will not be part of the overall treatment. The booster session's focus will be directed toward forming healthy relationships and relapse prevention. The intervention will be comprised of 18-24 participants, divided into three groups of six to eight members each, and each treatment group will be conducted consecutively. Each treatment group will meet weekly for 2 hours for five consecutive weeks. During the booster session, the group will meet for approximately 2.5 hours so that participants can complete the PHQ–SADS, DAST–10, AUDIT–C, and the end of treatment Group Satisfaction Survey (GSS). These groups will be facilitated by the researcher, who will be supervised by Ms. Sarah Marie Pierce, LCSW, the staff licensed clinical social worker, at the San Francisco Community Health Center; the groups will be conducted at SFCHC.

POTENTIAL RISKS AND DISCOMFORTS:
We do not anticipate any risks or discomforts to you from participating in this research; however, the research procedures described above may involve minimal emotional discomfort when completing survey questions and measures, especially those related to depressive symptoms, trauma, and substance use behaviors. If you wish, you may choose to withdraw your consent and discontinue your participation at any time during the study without penalty.

BENEFITS:
The possible benefits to you of participating in this study are, as follows:

1. Learn more about factors, such as depression, anxiety, minority stress, social support, individual acceptance, transphobia, social isolation, and gender abuse.
2. Learn more about CBT and how you can use it as a copy strategy in daily life.

PRIVACY/CONFIDENTIALITY:
Confidentiality means that the researcher will have a record of who participated but the information will be kept private. Any information you provide in this study will be kept confidential unless disclosure is required by law. In any report we publish, we will not include information that will make it possible to identify you or any individual participant. All paper work (i.e., informed consent forms, data collected from measures, demographic surveys, and participant and group satisfaction surveys) will be stored in a secure, locked file cabinet at the San Francisco Community Health Center, where the staff clinical social worker and I will be the only ones who will have key-access. A copy of the informed consent forms and any other paper materials obtained from you will also be kept in a locked file cabinet in my advisor's office at the University of San Francisco. My advisor and I will be the only ones who have key-access. Informed consent forms will be kept for three years, the minimum time prescribed by the University of San Francisco Internal Review Board.

COMPENSATION/PAYMENT FOR PARTICIPATION:

You will receive a total of $100.00 in cash for completing pre- and posttest measures, as well as satisfaction surveys for your participation in the study. You will be given $15.00 at the conclusion of each weekly session and $25.00 at the conclusion of the booster session. Meals will also be provided at each weekly session as well as at the booster session. Early withdrawal from the study will not result in any compensation.

VOLUNTARY NATURE OF THE STUDY:

Your participation is voluntary and you may refuse to participate without penalty or loss of benefits. Furthermore, you may skip any questions or tasks that make you uncomfortable and may discontinue your participation at any time without penalty or loss of benefits. In addition, the researcher has the right to withdraw you from participation in the study at any time. Withdrawal from the study will not affect your treatment or accessing resources at the San Francisco Community Health Center.

OFFER TO ANSWER QUESTIONS:
Please ask any questions you have now. If you have questions later, you should contact the principal investigators: Joy Ventura Riach at (707) 739-6650 or jlriach@usfca.edu and Dr. David A. Martinez at (415) 422-4247 or dmartinez9@usfca.edu. If you have questions or concerns about your rights as a participant in this study, you may contact the University of San Francisco Institutional Review Board at IRBPHS@usfca.edu.

I HAVE READ THE ABOVE INFORMATION. ANY QUESTIONS I HAVE ASKED HAVE BEEN ANSWERED. I AGREE TO PARTICIPATE IN THIS RESEARCH PROJECT AND I WILL RECEIVE A COPY OF THIS CONSENT FORM.

PARTICIPANT'S SIGNATURE DATE

APPENDIX M

Permission to Audio Record Group Sessions

I, _____, hereby give permission to Joy Riach,
(client's name)
a doctoral candidate at the University of San Francisco who is completing her clinical dissertation on THE EFFECTIVENESS OF A TRANSAFFIRMATIVE COGNITIVE BEHAVIORAL THERAPY GROUP-BASED INTERVENTION TO HELP TRANSGENDER WOMEN SUFFERING FROM DEPRESSION at the San Francisco Community Health Center to

audiotape_____ (initial if Yes)

our group session/s. I understand that these recordings will be used only for the purpose of evaluating the fidelity of the intervention and to provide clinical supervision to the candidate. The recordings will only be accessed by Joy Riach and Dr. David A. Martinez, who is the supervisor of this project and will be kept in password protected file and in a secured place by the candidate. Any person involved in a group therapy research study and who is providing or receiving clinical supervision is bound to the same ethical principles of confidentiality as professionals providing group therapy. All tapes of group sessions will be erased at the completion of the project. Any exception to this last statement would require an additional permission form to be signed by the client and doctoral candidate.

I understand that refusal to sign this form will not affect my eligibility for receiving services at this agency.

Signed _____ Date____/____/_____

Doctoral candidate _____ Date____/____/_____

APPENDIX N

Intervention Dates

Group I	11/12/19-12/10/19
Booster Session I	01/14/20
Group II	01/28/20-02/25/20
Booster Session II	03/24/20
Group III	02/19/20-03/18/20
Booster Session III	04/15/20
Data Analysis	May-October 2020
Dissertation Report Writing	May-November 2020
Dissertation defense meeting with committee members	November 23, 2020